CONDITION OF STATE AGENCIES THAT DETERMINE DISABILITY UNDER SOCIAL SECURITY

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

OCTOBER 6, 1987

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CONDITION OF STATE AGENCIES THAT DETERMINE DISABILITY UNDER SOCIAL SECURITY

TUESDAY, OCTOBER 6, 1987

House of Representatives,
Committee on Ways and Means,
Subcommittee on Social Security,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room B-318, Rayburn House Office Building, Hon. Andy Jacobs, Jr. (chairman of the subcommittee) presiding.

[Press releases announcing the hearing follow:]

FOR IMMEDIATE RELEASE
TUESDAY, JUNE 9, 1987

SUBCOMMITTEE ON SOCIAL SECURITY #5
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-3627

ANDY JACOBS, JR. (D., IND.), CHAIRMAN, SUBCOMMITTEE ON SOCIAL SECURITY, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON THE CONDITION OF STATE AGENCIES THAT DETERMINE DISABILITY UNDER SOCIAL SECURITY ON WEDNESDAY, JULY 1, 1987, AT 9:30 A.M., IN ROOM B-318 RAYBURN HOUSE OFFICE BUILDING

Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee will conduct a hearing on the condition of State agencies that determine disability under the Social Security Disability Insurance program. The hearing will be held on Wednesday, July 1, 1987, in room B-318 Rayburn House Office Building, beginning at 9:30 a.m.

ISSUES

The Subcommittee will receive testimony from the Social Security Administration (SSA), the General Accounting Office, and interested public witnesses. The hearing will focus on several issues:

1. Have the severe restrictions placed by SSA on State agency funding and staffing levels jeopardized the ability of the State agencies to properly implement the provisions of the Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460)?

2. How have the State agencies responded to these budgetary constraints, and has this led to any deterioration in the quality and thoroughness of disability case development, documentation, and review?

3. Are SSA's productivity guidelines realistic, and is the method SSA utilizes to measure productivity accurate, consistent, or nationally uniform? If not, how could these productivity standards be improved?

4. Does a climate of crisis and disruption continue to plague the day-to-day administration of the disability program, and if so, how can order and stability -- the key objectives of the 1984 legislation -- be restored to the administrative process?

5. What is the condition of Federal-State relations in administering the disability program, and what steps can be taken to improve the development and implementation of budgetary and adjudicative policy?

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

Requests to be heard must be made by telephone to Harriett Lawler [telephone (202) 225-3627] by the close of business Wednesday, June 24, 1987. In order to facilitate scheduling, requests should indicate the specific issues which the witness wishes to address and the relative priority of each issue if more than one issue is indicated. The request should be

(OVER)

followed by a formal written request addressed to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, room 1102 Longworth House Office Building, Washington, D.C. 20515. The Subcommittee will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the Subcommittee staff [(202) 225-9263].

In view of the limited time available to hear witnesses, the Subcommittee may not be able to accommodate all requests to be heard. Those persons and organizations not scheduled for an oral appearance are encouraged to submit written statements for the record of the hearing. All persons requesting to be heard, whether they are scheduled for oral testimony or not, will be notified as soon as possible after the filing deadline.

Witnesses scheduled to present oral testimony are required to briefly summarize their written statements in no more than five minutes. THE FIVE-MINUTE RULE WILL BE STRICTLY APPLIED. The full statement will be included in the printed record.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, witnesses scheduled to appear before the Subcommittee are required to submit 100 copies of their prepared statements to the Subcommittee on Social Security office, room B-316 Rayburn House Office Building, at least 24 hours in advance of their scheduled appearances. Failure to do so may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements in lieu of a personal appearance should submit six (6) copies of their statements by the close of business Wednesday, July 15, 1987, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, room 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing a written statement for the record of the printed hearing wish to have their statement distributed to the press and the interested public at the hearing, they may provide 75 additional copies for this purpose to the Subcommittee office, room B-316 Rayburn House Office Building, during the course of the public hearing.

SEE FORMATTING REQUIREMENTS BELOW:

COMMITTEE ON WAYS AND MEANS FORMATTING REQUIREMENTS FOR PRINTING OF HEARING STATEMENTS, WRITTEN COMMENTS AND EXHIBITS

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

**** NOTICE -- POSTPONEMENT ****

FOR IMMEDIATE RELEASE
FRIDAY, JUNE 26, 1987

PR #6
SUBCOMMITTEE ON SOCIAL SECURITY
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-3627

ANDY JACOBS, JR. (D., IND.), CHAIRMAN, SUBCOMMITTEE ON SOCIAL SECURITY, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A POSTPONEMENT OF THE HEARING ON THE CONDITION OF STATE AGENCIES THAT DETERMINE DISABILITY UNDER SOCIAL SECURITY

Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, announced today that the hearing on the condition of State agencies that determine disability under the Social Security Disability Insurance program has been postponed. The hearing had previously been scheduled to be held on Wednesday, July 1, 1987, in room B-318 Rayburn House Office Building, beginning at 9:30 a.m (see Press Release #5).

A new date, time, and location for this hearing will be announced later.

######

FOR IMMEDIATE RELEASE
THURSDAY, SEPTEMBER 17, 1987

SUBCOMMITTEE ON SOCIAL SECURITY #7
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-3625

ANDY JACOBS, JR. (D., IND.),
CHAIRMAN, SUBCOMMITTEE ON SOCIAL SECURITY,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES HEARINGS ON THE CONDITION OF STATE AGENCIES THAT
DETERMINE DISABILITY UNDER SOCIAL SECURITY, AND
ON H.R. 2259, CONCERNING COVERAGE OF AMISH WORKERS,
ON TUESDAY, OCTOBER 6, 1987, AT 10:00 A.M.,
IN ROOM B-318 RAYBURN HOUSE OFFICE BUILDING

Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee has rescheduled a hearing on the condition of State agencies that determine disability under the Social Security Disability Insurance program (see press releases #5 and #6), and on the current status of new attorney fee regulations in light of Committee-approved legislation on the fee process. The hearing will be held on Tuesday, October 6, 1987, in room B-318 Rayburn House Office Building, beginning at 10:00 a.m.

Immediately following the conclusion of the disability hearing, the Subcommittee will hold a hearing on H.R. 2259 (cosponsored by Messrs. Schulze, Vander Jagt, Daub, et al) concerning social security coverage of Amish workers. Testimony will be received at the second hearing only from invited witnesses.

SOCIAL SECURITY DISABILITY ISSUES

The Subcommittee will receive testimony from the Social Security Administration (SSA), the General Accounting Office, and interested public witnesses. The hearing will focus on several issues:

1. Have the severe restrictions placed by SSA on State agency funding and staffing levels jeopardized the ability of the State agencies to properly implement the provisions of the Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460)?

2. How have the State agencies responded to these budgetary constraints, and has this led to any deterioration in the quality and thoroughness of disability case development, documentation, and review?

3. Are SSA's productivity guidelines realistic, and is the method SSA utilizes to measure productivity accurate, consistent, or nationally uniform? If not, how could these productivity standards be improved?

4. Does a climate of crisis and disruption continue to plague the day-to-day administration of the disability program, and if so, how can order and stability -- the key objectives of the 1984 legislation -- be restored to the administrative process?

5. What is the condition of Federal-State relations in administering the disability program, and what steps can be taken to improve the development and implementation of budgetary and adjudicative policy?

6. Despite approval by the full Committee on Ways and Means, the Social Security Administration is pursuing new attorney fee regulations which appear to be contradictory to the goals of the legislation. What are the agency's intentions in pursuing these new regulations?

AMISH EMPLOYEE COVERAGE ISSUES

Under current law, self-employed Amish who have religious objections to participation in the social security system are exempt from coverage. The hearing will focus on whether that exemption should extend to Amish employees of Amish employers.

(OVER)

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

Requests to be heard at the disability hearing must be made by telephone to Harriett Lawler [telephone (202) 225-3625] by the close of business Tuesday, September 29, 1987. In order to facilitate scheduling, requests should indicate the specific issues which the witness wishes to address and the relative priority of each issue if more than one issue is indicated. The request should be followed by a formal written request addressed to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, room 1102 Longworth House Office Building, Washington, D.C. 20515. The Subcommittee will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the Subcommittee staff [(202) 225-9263].

In view of the limited time available to hear witnesses, the Subcommittee may not be able to accommodate all requests to be heard. Those persons and organizations not scheduled for an oral appearance are encouraged to submit written statements for the record of the hearing. All persons requesting to be heard, whether they are scheduled for oral testimony or not, will be notified as soon as possible after the filing deadline.

Witnesses scheduled to present oral testimony are required to briefly summarize their written statements in no more than five minutes. THE FIVE-MINUTE RULE WILL BE STRICTLY APPLIED. The full statement will be included in the printed record.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, witnesses scheduled to appear before the Subcommittee are required to submit 100 copies of their prepared statements to the Subcommittee on Social Security office, room B-316 Rayburn House Office Building, at least 24 hours in advance of their scheduled appearances. Failure to do so may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of either hearing should submit six (6) copies of their statements by the close of business Tuesday, October 20, 1987, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing a written statement for the record of the printed hearing wish to have their statements distributed to the press and the interested public at either hearing, they may provide 75 additional copies for this purpose to the Subcommittee office, room B-316 Rayburn House Office Building, during the course of the public hearing.

SEE FORMATTING REQUIREMENTS BELOW:

COMMITTEE ON WAYS AND MEANS FORMATTING REQUIREMENTS FOR PRINTING OF HEARING STATEMENTS, WRITTEN COMMENTS AND EXHIBITS

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

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2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman JACOBS. The hearing today is on the question of whether we are dangerously overstaffed, dangerously understaffed, or just right for the efficient administration of the Social Security disability insurance program.

Our first witnesses appear from the U.S. General Accounting Office. I wish you would proceed in your own manner.

STATEMENT OF FRANKLIN FRAZIER, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY BARRY TICE, CAMEO ZOLA, AND JOSEPH LAW, SOCIAL SECURITY AUDITORS

Mr. FRAZIER. Good morning Mr. Chairman and members of the subcommittee. I have with me today Mr. Barry Tice, Mr. Cameo Zola and Mr. Joe Law from our Social Security audit site.

We are pleased to be here today to discuss some of the effects of the budget constraints on the disability determination service organizations and to provide you with our assessment of the Social Security Administration's productivity guidelines.

The $4 billion administrative budget of the Social Security Administration was reduced by $171 million for fiscal year 1987. As a result of the $171 million budget reduction, the Social Security Administration reduced the 1987 State disability determination services' budgets by $19 million. This is a 2.5 percent reduction.

Additionally, the Social Security Administration reduced the State staff year allocation by 499 staff years, which represented a 3.7 percent reduction.

To offset the budget reduction of $19 million and a staff cut of 499 staff years, the Social Security Administration reduced the States' work load by 262,000 continuing disability reviews. The reduction of the continuing disability reviews, which were mandated by the 1980 Social Security Amendments, is the most significant measurable effect of the budget constraints on the State disability services because these reviews remove people who have medically improved from the disability roles and, consequently, they save dollars.

The Social Security Administration's actuary office estimates a cost savings of $8 to $9 million for every 10,000 continuing disability reviews where medical improvement is expected. Using the actuarial office data, we estimate that the disability insurance trust fund will pay out approximately $200 million for the 262,000 continuing disability reviews which were not done because of budget constraints.

State officials have also told us that the budget constraints are having negative effects, such as delays in assignment of cases to examiners, increase in examiners' case loads, delays in physician reviews, and the use of quality assurance staff to process the cases. However, we have found no empirical evidence to indicate that the quality of the decision making process has deteriorated as a result of these actions.

I will now discuss the Social Security Administration productivity guidelines. The Social Security Administration's current productivity standard is based on a production per work year basis. Simply, this means that the standard is based on the number of cases processed in a year divided by the total number of staff years used to process the cases.

We do not believe that the current system is realistic nor accurate because of the following. The current system does not account for variances in how various States operate. For example, some States contract for some services which others do in-house. The current system does not account for the variance in case mixes by program or by types of impairment. Yet, the type of impairment or type of case mix can make a significant difference in the amount of time required to process the cases.

For example, State officials told us that mental cases take approximately twice as much time to process than other types of cases. The current system also does not account for services provided by other State agencies to the disability offices, such as personnel and ADP services.

The Social Security Administration has recognized the problems with its production per work year standard and has proposed a new system called a cost effectiveness measurement system. We believe the new cost effectiveness measurement system is more realistic in concept and should provide a more accurate measure of productivity.

However, the cost effectiveness measurement system has one flaw in that it does not account for case mix by type of impairment.

Mr. Chairman, within the next few days, we will provide you with a copy of a report that covers the points that I have just made. Our report will recommend to the Secretary of Health and Human Services that they provide the resources to the States to process the backlog of continuing disability review cases because they save money and are required by law.

We are also recommending that the new cost effectiveness measurement system be modified to account for case mix by type of impairment.

This concludes my statement and we will be pleased to respond to your questions.

[The statement of Mr. Frazier follows:]

United States General Accounting Office

GAO Testimony

Statement of
Franklin Frazier, Associate Director
Human Resources Division

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here to discuss the effects of recent budgetary constraints imposed on the state disability agencies by the Social Security Administration (SSA), a subject discussed in a report soon to be issued to your Committee[1]. During fiscal year 1987, and continuing at least into fiscal year 1988, most of the state disability determination services (DDSs) have been required to reduce staff levels, generally through attrition. SSA officials imposed these reductions after the Congress reduced SSA's fiscal year 1987 administrative budget request of about $4 billion by $171 million.

In January 1987, noting that state agencies were asserting that they were not receiving enough resources to perform effectively, you asked us to review and analyze several issues surrounding DDS funding and staffing. Specifically, you asked that we (1) address the effects of the budget constraints on the DDSs and (2) assess whether SSA's productivity standards are realistic, accurate, and nationally uniform.

We met with SSA staff involved in the budget process and reviewed data on DDS claims workload, staffing, operating costs, and other operational characteristics. We also visited five state agencies (Texas, Pennsylvania, Massachusetts, Louisiana, and Georgia) in February and March 1987 and analyzed data from questionnaires we mailed to 53 DDSs.

Our observations follow:

-- SSA chose to hold the fiscal year 1987 budget for the DDSs to the same level as initially budgeted for 1986, resulting in 3.7 percent fewer work-years for 1987 than used in fiscal year 1986. Forty DDSs had reductions in their staffing levels. In fiscal year 1988 SSA plans to make an additional 3.5-percent reduction in DDS staff resources.

-- Because of the reductions to DDS staff, SSA limited the number of continuing disability reviews (CDRs) it required the states to do in fiscal year 1987 to 216,000. SSA plans about the same workload level for fiscal year 1988. These reviews, legally required every 3 years, assess whether individuals on the disability rolls, whose conditions have not been considered to be permanent, have medically improved enough to work. This was a reduction in CDR workload of 262,000 from what was in the initially proposed budget for FY 1987. Not processing these CDRs may cost the trust fund over $200 million in annual benefit payments, or about three times the administrative costs saved by not doing the reviews. The same situation will probably exist in fiscal year 1988 unless SSA gives DDSs more resources. Given the large potential saving to the trust fund, SSA should provide the resources to process the CDRs. If sufficient funds are not available in SSA's budget, legislative authority should be sought to expend additional trust funds to process the cases where medical improvements are expected.

-- SSA's current measure of DDS productivity, which was used to allocate staff to DDSs, does not allow for accurate or uniform comparisons of DDSs' productivity. SSA is developing a more accurate productivity measurement system, which will take into account the many variances in DDS staffing and operating practices.

---

[1] Social Security Disability: Effects of Budget Constraints on Disability Program (GAO/HRD-88-2, Oct. 1987).

— Many of the DDS administrators and examiners we spoke to expressed concern that increasing pressures to process more cases with fewer staff could lead to shortcuts in the decision-making process at the DDSs and deterioration in the quality of case reviews.

The remainder of my testimony details these points.

REDUCING CDR WORKLOADS WILL COST MORE IN UNWARRANTED PAYMENTS THAN SAVED IN ADMINISTRATIVE EXPENSES

Generally, there are three types of disability workloads processed by DDSs—initial applications for benefits, requests for reconsideration reviews, and CDRs. Initial applications and reconsiderations are considered priority and "nondiscretionary." CDRs, on the other hand, are considered "discretionary," despite a provision in the Social Security Disability Amendments of 1980, requiring SSA to review beneficiaries whose conditions are not considered permanent at least every 3 years.

SSA's fiscal year 1987 budget submission to the Congress in March 1986 requested $760 million (including 13,750 work-years) for the DDSs to administer an estimated disability workload of 2.8 million cases, including about 478,000 CDRs.

When the Congress reduced SSA's total requested administrative budget for fiscal year 1987 by $171 million, SSA reduced the overall DDS budget by about 2.5 percent, or about $19 million. DDS work-years were also reduced to 329 less than the work-years expended in fiscal year 1986, and SSA reduced its planned CDR workload by 255,000 cases.

In December 1986, SSA made further reductions to the DDS budgets. Total state work-years were reduced to 12,880 (or 499 less than the work-years expended in fiscal year 1986), and the estimated workload was reduced by about 81,000 cases (this included a reduction of 7,000 CDRs). Funds for purchasing medical evidence were also adjusted downward.

Although the overall fiscal year 1987 budget for the DDSs remained the same as the initial budget for fiscal year 1986, 40 DDSs had reductions in their staffing levels, and 41 had reductions in the funds they could use for procuring medical evidence. In effect, the DDSs experienced a budget cut of $14 million from 1986 levels because, during 1986, they were allocated $14 million more than the initial budget.

Because of the moratorium on CDRs from April 1984 to the end of December 1985 and the slow start-up of the CDR process in 1986, there are over 300,000 medical improvement expected cases for which scheduled review dates are past due. In addition, new medical improvement expected cases are having their scheduled review dates come "due" at the rate of about 12,500 a month. As of July 31, 1987, the DDSs had averaged adjudication of these cases at the rate of about 6,100 a month.

SSA's Office of the Actuary projects that, for every 10,000 medical improvement expected cases that are not reviewed, the Disability Insurance Trust Fund experiences unnecessary benefit payments of $8 to $9 million per year. SSA's projection is based on a cessation rate for medical improvement expected cases of about 20 percent, and allows for reversals of some cessation decisions following appeals. These annual payments will continue until such reviews are performed, or the individuals otherwise leave the benefit rolls.

With this amount of savings to be achieved by doing CDRs, the 262,000-CDR-case reduction in the 1987 budget represents an annual cost to the trust fund of more than $200 million in benefits. Estimated annual savings from processing these CDRs are about three times the administrative expenses saved by not doing CDRs. In addition, eventually these cases should be reviewed and the administrative costs to do them would be incurred at that time. In the meantime, each year's delay costs the trust fund the benefits that should not have been paid.

PRODUCTIVITY MEASUREMENTS AND EXPECTATIONS

To allocate resources among the DDSs, SSA used a productivity measurement system referred to as production per work-year. This means the amount of work produced (measured in cases completed), divided by the number of work-years used to complete that work. Once a national production goal was established for fiscal year 1987, staffing levels and production goals were set by SSA for each DDS, considering a number of factors, including expected workload, existing staffing, and planned attrition. Using these data, SSA headquarters staff made the final judgments on each DDS's staff level.

Some DDS officials raised concerns, during our DDS visits and in response to our questionnaire, over the use of this measure as a means of comparing DDS productivity and as a means to address DDS staffing levels. When asked whether a different productivity measure would give a better comparison among DDSs, 33 (62 percent of those responding) said yes. Most identified the Cost Effectiveness Measurement System, a new system being developed by SSA, as a better system for measuring and comparing DDS productivity. Others suggested limiting the current measurement system to productivity of examiners and medical staff rather than including all DDS staff.

SSA's current measurement system considers all disability workloads the same, and counts only in-house DDS staff. It does not account for the many variances in DDS operations, particularly such differences as use of contracted labor, type of cases, and level or magnitude of assistance provided by other state agencies. For example, 43 of the 53 DDSs responding to our questionnaire were contracting for various services in 1987, including medical services, transcribing services, clerical personnel, computer services, mail services, security, and legal services. The 43 DDSs estimated that the contracted services cost more than $16 million for the year and would be equivalent to over 450 work-years if done in house.

The relative proportion of certain types of impairments in a DDS's workload can affect productivity. For example, some DDSs estimate that mental impairment cases take at least twice as many examiner and medical staff hours as other cases. In 1986, about 35 percent of the DDSs' initial disability decisions involved mental impairment cases. The proportion of mental cases adjudicated ranged from 22 percent in Nevada to 46 percent in Ohio.

SSA has recognized most of the weaknesses of its current measurement system. Because operating conditions vary greatly from state to state, SSA's new system will automatically adjust each DDS's reported cost and productivity data to reflect certain factors beyond the DDS control, such as case mix by program and adjudication level, and costs of outside services.

One factor the new system does not consider, which we believe is important, is the case mix by type of impairment. For example, some DDSs have significantly higher proportions of mental impairment cases, which take longer to do, and this should be accounted for in productivity comparisons.

AT WHAT PRODUCTION LEVEL DOES QUALITY DETERIORATE?

In addition to the impact on doing CDRs, the budget limitations could also affect the quality of disability determinations. While the 1984 disability amendments called for more extensive case development, the increasing pressures of doing more cases with fewer examiner and physician staff could lead examiners to take shortcuts. This could have an adverse effect on the quality of decisions, although we found no empirical evidence that was occurring.

As can be seen in the following table, the overall production per DDS work-year has declined since fiscal years 1980 and 1981. Some of this decline can be attributed to reduced workloads caused by the CDR moratorium. However, DDS administrators and examiners we spoke with said that the primary cause was the increased demand for more complete case development and more complex decision issues (e.g., mental impairments, multiple impairments, pain).

National Production

Fiscal year	Workloads	Work-years	Production per work-year
1980	2,326,600	9,701	240
1981	2,376,700	10,747	221
1982	2,480,068	12,399	200
1983	2,615,973	12,775	205
1984	2,264,723	12,776	177
1985	2,001,062	12,807	156
1986	2,229,718	13,379	167
1987*	2,463,727	12,880	191

*Budgeted as of December 1986 and not adjusted for a uniform workweek among all DDSs. During 1987, SSA adjusted work-years for the DDSs based on a standard workweek. We are showing unadjusted work-years here to keep 1987 on the same scale as the prior years.

SSA's production goal of 191 cases per work-year is similar to overall DDS production in the 2 years before the 1984 disability amendments. During 1982 and 1983 the DDSs' workloads were very high, and the adjudication system was under constant criticism for inadequate case development practices and resultant poor quality decisions, particularly in mental impairment cases. The 1984 Amendments prescribed standards of case review to improve the quality of decisions. The standards included more comprehensive development of evidence and more careful consideration of individual cases. We are concerned that actions taken to meet high production levels may result in declining service to beneficiaries and poor quality decisions.

From our visits to five DDSs and responses to our questionnaire, we learned of various concerns regarding possible negative impacts in states' disability operations because of the resource cuts in 1987, some of which could affect the quality of the disability determinations. The DDSs said that CDR hearings had been postponed, there were delays in assigning cases to examiners, examiner caseloads had been increased, physician reviews had been delayed, and other staff, such as quality assurance staff, were used to process cases. To update this informaton we contacted 25 states by telephone in September 1987 and found that the earlier comments and observations had not changed.

We examined data on the last 6 years of DDSs' performance. In many elements of performance, there are wide variances among the DDSs, including variances in production, timeliness, staffing, and claim allowance rates. How these differences affect quality, and at what point quality may deteriorate, are major questions for which we do not have answers at this time.

We intend further study of productivity issues and their effect on case development and quality.

CURRENT STATUS

Data for the first 11 months of fiscal year 1987 showed that the national production per work-year was 187. Adjusted for a standard workweek, it was 192.3. Thirty-four of the DDSs were below their productivity goal. During the first 10 months the DDSs have completed about 128,500 CDRs.

For fiscal year 1988, SSA is planning an increase in the overall DDS operating budget of 1.7 percent, or about $13 million over the fiscal year 1987 level. Associated with this is a small (10,741-case) increase in the national workload. SSA is planning to hold the CDR workload to about 3 percent more than the 1987 level of 216,000. Also, SSA plans to reduce the DDSs' staffs by about 3.5 percent below the 1987 level. The budgeted fiscal year 1988 work-years will be at one of the lowest levels during the decade, while the expected workload will be at one of the highest levels.

In view of a legal mandate to process most of these cases every 3 years, and the large potential savings to the trust fund, we believe SSA should seek sufficient resources, given productivity improvements in the DDSs, to process the CDR cases where medical improvement is expected.

This concludes my statement. We will be pleased to answer questions.

Chairman **Jacobs**. Mr. Frazier, to summarize with respect to the disability system, what is the level of staff personnel now and what, in the opinion of the GAO, should it be?

Mr. **Frazier**. The staff level now is approximately 12,500 people. I do not believe that I can answer exactly what it should be.

Chairman **Jacobs**. Then let us go with approximately.

Mr. **Frazier**. With approximately what it should be? Sir, that will be a difficult question to answer because we do not have a good measurement of productivity. It is our opinion that with the new system, when we find out what the different case mixes are and how much time it takes to process the various case mixes, we will be at that particular time able to estimate, with some reasonable amount of assurance.

Chairman **Jacobs**. Can you at least say whether it is sufficient? The personnel level is sufficient at this time?

Mr. **Frazier**. I think that in terms of sufficient, we did have a questionnaire that went out to the States. The State officials do not believe that they are sufficiently staffed. The State officials are telling us that the caseloads are increasing and that they are having to use different kinds of staff people, like their quality assurance people, to process cases.

So from a point of view of the State officials, they believe that it is insufficient. But I cannot——

Chairman **Jacobs**. But you are a referee and they are players.

Mr. **Frazier**. I am sorry?

Chairman **Jacobs**. I say the GAO is more in the nature of a referee and I just wonder if there was any horseback opinion, one way or another. It is a very controversial matter and you seem to perceive that.

Mr. **Tice**. The primary point that we made in the testimony this morning, and we are making in the report that you will be receiving in the next day or two, is that the resources are insufficient to process the continuing disability workload.

Chairman **Jacobs**. Thank you. I believe also, the GAO holds the opinion, in consequences, it is a study that may be fiscally unproductive as well, from the point of view of taxpayers?

Mr. **Frazier**. That is correct.

Chairman **Jacobs**. Okay. Thank you very much for your contribution to the record. We appreciate it.

The next witness is David A. Rust, Associate Commissioner for Disability, Social Security Administration. Mr. Rust.

I might announce for the record, and for the edification of succeeding witnesses, that the subcommittee is disposed to indulge Government witnesses with such time as they may require, but witnesses from private organizations will be held strictly to the 5-minute rule. They apply that rule on the floor of the U.S. House. A Representative is often stopped mid-syllable, and that is the policy we try to follow here. It is a kindness to those who are at the end of the list, as well as those who are at every point in the list, namely the members.

Please proceed, sir.

STATEMENT OF DAVID A. RUST, ASSOCIATE COMMISSIONER FOR DISABILITY, SOCIAL SECURITY ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY LENORE CARLSON, DIRECTOR, DIVISION OF FIELD OPERATIONS

Mr. RUST. Thank you, Mr. Chairman and I will do everything I can to stay close to 5 minutes in my opening remarks.

I am accompanied today by Lenore Carlson, who is the Director of our Division of Field Operations.

I am pleased to be here today, Mr. Chairman, to discuss the Social Security Disability Program and the steps we have taken to improve the management of our program.

Let me say at the outset that we believe that the condition of this program is better now than it has been for years and will continue to improve. In the 3 years since the 1984 Disability Amendments were enacted, SSA and the States have implemented significant changes in disability policies and procedures; largely completed a special one-time workload of cases to be re-reviewed; and resumed the CDR process.

In planning the CDR process for fiscal year 1987, the first full year of implementation, we wanted to assure that the DDS adjudicators had a complete understanding of the medical improvement review standard. We also tried to balance the congressional mandate to conduct CDRs with the need to regain the confidence of the public in the CDR process.

In fiscal year 1987, we completed about 216,000 cases, an annual level above the number of reviews conducted before fiscal year 1981 but below the high levels of 1982 and 1983. In general, SSA and the disability determination services [DDS] can be proud of this accomplishment.

In fiscal year 1987, we initially experienced a decline in overall quality of DDS decisions because of some problems that surrounded the application of the mental impairment rules. These are new and very complicated rules, Mr. Chairman. A lot of training and a lot of retooling had to go into their implementation.

Joint SSA and DDS actions to assure the correct application of these rules have resulted in a continual increase of the overall accuracy rate of disability decisions, bringing it up to 94.7 percent for the 3 months ending in August of 1987.

I am personally committed to maintaining and improving the quality of the DDS decisionmaking process.

As you know, Mr. Chairman, there has been much discussion about the resources available to the DDS's in fiscal year 1987. These resources were based on the conference committee recommendation that accompanied the fiscal year 1987 budget resolution. The committee recommended that the amount available nationally in fiscal year 1987 be the same as was authorized in fiscal year 1986—$741.2 million.

We have administered the program within this budget without compromising quality or our commitment to implement the 1984 amendments.

We have managed our work and our resources well. A review of the history of the DDS expenditures and productivity may be helpful in understanding our actions in fiscal year 1987. During the period from 1980 to 1986, there was a 221 percent increase in DDS funding, but a 33 percent decrease in productivity—from 248 to 168 case dispositions per work year.

Mr. Chairman, I would draw your attention to chart A which accompanies my testimony and reflects these productivity changes.

Some of these differences can be explained by the more labor intensive disability case processing requirements contained in the 1980 and 1984 amendments to the act. In addition, staffing levels in the DDS's were maintained during the period of the CDR moratorium when work loads dropped dramatically. As a result, the DDS's have become accustomed to an artificially reduced productivity level and those are reflected in charts B and C which accompany my testimony.

While we do not think that the pre-1982 productivity levels are within reach under present law and regulations, we do not believe that the 1980 and 1984 amendments were so labor intensive as to justify a permanent 33 percent reduction in productivity. We, therefore, set a national target for case disposition per work year of 195. We use the term productivity per work year, or, PPWY for that, Mr. Chairman.

This level allowed us to live within the $741.2 million allocation and to increase national productivity to a more stable and realistic level. Our national cumulative case dispositions per work year in fiscal year 1987 was 192, so we fell just slightly short of our national goal. The average for the last 3 months was 201, so productivity rose throughout the year, peaking above our national goal in the fourth quarter.

This increase in productivity has been accomplished during the same period of time when quality improved and processing time decreased. Our national productivity target for fiscal year 1988 is 204.7 cases and resources available to the DDS's in fiscal year 1988 will be $754 million, barring any change made by the Congress in the appropriations process.

We also decided to establish equity in the deployment of resources among the States. During the 1980's, significant differences in program administration developed from State to State. In fiscal year 1986, individual State productivity ranged from 90 to 280 case dispositions per work year. We chose to return to a more equitable distribution of funds over a period of several years, thus avoiding a reduction in force in low-producing States.

Low-producing States have been placed under a hiring freeze until they achieve a PPWY of 195. Higher producing States are now able to use a higher proportion of the available national resources. Through this process, we are narrowing the productivity gap and, I might add, promoting consistency in national administration to the program.

We know that Congress has long been concerned about the need for uniform disability program administration. The 1980 amendments gave SSA greater control and oversight over the DDS's. Numerous GAO reports have addressed the need for us to improve program management.

We have not been dogmatic in our approach to this process or to our goal of equity. We have sent out, Mr. Chairman, an annual planning figure this year well in advance of the beginning of the fiscal year which has allowed the States time to negotiate with us and to work out anomalies that may exist from State to State.

We have established what we believe to be more effective communication between the Social Security Administration and the States and we have been able to accommodate national expectations to state specific problems. We have made a number of adjustments during the course of fiscal year 1987, and we will make adjustments during the course of fiscal year 1988, as particular problems develop in each State. Our goal has been to work out the problems so that everyone operates the best and most consistent program possible.

We have actively worked with the States on ways to simplify and streamline the determination process and have already put several simplifications in place. We are also upgrading the DDS automated information system so that SSA and DDS managers can identify and analyze problems earlier and take swift remedial action.

Effective management in an era of fiscal constraint is a challenge, Mr. Chairman. SSA and the DDS's must continue to be strong, well managed organizations, working together to assure high quality service to our disability claimants and beneficiaries.

I intend to fully support those DDS's working to resolve operational and administrative problems. We will work with them to achieve our joint objectives of cost-effectiveness, quality, and productivity.

I also intend to stand firm in reassuring the Congress that the disability program is administered in a nationally uniform way, that State decisionmaking and management are in full compliance with the law, and that each State is provided with the necessary funds—equitably deployed—to do a high quality job.

I look forward to working with you and the States to achieve these goals.

Mr. Chairman, that concludes my testimony and I will be happy to answer any questions you may have to the best of my ability.

[The statement of Mr. Rust follows:]

STATEMENT OF DAVID A. RUST, ASSOCIATE COMMISSIONER FOR DISABILITY, SOCIAL SECURITY ADMINISTRATION

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Social Security disability program and the steps we have taken to improve the management of the program. I would also like to say a few words about our implementation of the 1984 disability amendments that were signed into law 3 years ago on October 9, 1984.

The last decade has been a period of intense interest in the disability program--marked by extensive General Accounting Office (GAO) studies, far-reaching congressional oversight, implementation of the 1980 amendment provision mandating periodic continuing disability reviews (CDRs) of all beneficiaries, numerous law suits challenging our administration of the program, Secretary Heckler's moratorium on CDRs, implementation of the 1984 amendments, and the gradual resumption of the CDR process.

When President Reagan signed the 1984 disability amendments into law, he said, "This legislation, which has been formulated with the support of the Administration and passed by unanimous vote in both Houses of Congress, should restore order, uniformity, and consensus in the disability program." Let me say at the outset that we believe that the President was correct in his prediction and the condition of the disability program is better than it has been for years and will continue to improve. After the difficult years preceding enactment of the 1984 legislation, the disability program has been strengthened and improved and is moving into a period of stability.

The Social Security Administration (SSA) administers this program through 54 State agencies that make disability determinations in both the Social Security disability insurance (SSDI) and the supplemental security income (SSI) programs. Our unique relationship with the State agencies, often referred to as disability determination services (DDSs), has been in existence for over 32 years and is one we want to preserve.

IMPLEMENTATION OF THE 1984 DISABILITY AMENDMENTS

The 1984 disability amendments represented a sweeping change for SSA and the DDSs--with perhaps the most dramatic effect on administration of the disability program since we implemented the SSI program in 1974. In the 3 years since the amendments were enacted, we have:

- published and implemented six final regulations including two on the key provisions of the amendments--the medical improvement review standard for CDRs and the revised standards for evaluating mental impairments;
- published five regulations on amendment provisions as notices of proposed rulemaking; these should be published as final regulations this fall;
- conducted extensive training of DDS adjudicators and carried out special reviews of DDS decisions made under the new rules to make sure decisions accurately follow the rules;
- largely completed special one-time workloads resulting from rereviews of certain claims required under the medical improvement standard and mental impairment provisions of the amendments;
- resumed the CDR process under the medical improvement standard of the amendments with about 216,000 dispositions in fiscal year (FY) 1987; and
- submitted eight reports to Congress on implementation of various provisions of the amendments. These included the report by the congressionally mandated Commission on the Evaluation of Pain which recommended that the 1984

amendment statutory standard for the evaluation of pain be extended until additional studies and experiments on pain and disability recommended by the Commission could be completed.

CDR Process In FY 1987

The most significant provision in the 1984 amendments is the medical improvement standard for CDRs. Therefore, I would like to briefly describe the CDR process in FY 1987--our first full year of implementation.

In planning the CDR process for FY 1987, we intended to assure that the DDS adjudicators had a complete understanding of the medical improvement review standard so as to produce fair and equitable results for beneficiaries. We completed about 216,000 cases, an annual level above the number of reviews processed prior to FY 1981 but below the high levels of 1982 and 1983.

In FY 1987, we also tried to effectively balance the congressional mandate to conduct CDRs with the need to regain the confidence of the public and the States in the CDR process.

Our planning in FY 1987 incorporated these objectives:

- We concentrated on CDR cases with the greatest likelihood of medical improvement. This was in accord with a GAO recommendation to Commissioner Hardy that we look first at cases with the highest likelihood for medical improvement.
- We decided not to process cases where medical improvement was not expected until the DDSs become current with other categories of CDRs. This was also in accord with a recommendation from GAO.
- We first processed cases returned to us from the courts in which actions had been pending for some time. We also did early quality reviews of cessation cases in all States so that SSA could be assured that our instructions to adjudicators were clear.
- We carefully considered States' concerns about their ability to process the additional workload by planning a slow release of CDRs in the first quarter of FY 1987. This was intended to allow each State to clear its remaining mental impairment review cases and bring down its overall volume of pending cases before full-scale processing of CDRs. During the first quarter, the national DDS pending workload was reduced by 90,000 cases, and States were in a better position to handle their total workloads.

Our planning in FY 1988 includes budgeting for 216,000 CDR dispositions. Also, in FY 1988, we will be piloting procedures for processing periodic CDRs within SSA while the DDSs concentrate on becoming current with the medical-improvement-expected cases.

ACCURACY OF DECISIONMAKING

I am personally committed to maintaining and improving the accuracy of DDS decisions. Accuracy has to be monitored especially closely at a time when new policies and legislation are being implemented. As fine-tuning of new policies occurs, extensive training (and sometimes retraining) has to be actively pursued.

The implementation of the mental impairment regulation in August 1985 and the medical improvement review standard regulation in December 1985 dramatically changed the operation of the disability program. Training in all States was a major activity and transitional workloads were high, especially with the addition of almost 200,000 reviews of prior mental impairment denials and a start of CDRs under the new medical improvement policy.

Problems with the application of the mental impairment rules produced a decline in overall accuracy of DDS disability decisions. However, by refining operational guidelines to ensure more consistent use of the mental-impairment criteria, the accuracy rate is now 94.7 percent for the 3 months ending August 1987 (the most recent data available). (Accuracy for this purpose is defined as a correct decision with sufficient documentation to support the decision.)

NATIONAL DDS RESOURCES

As you know, Mr. Chairman, resources available to the DDSs in FY 1987 were based on the Conference Committee recommendation on the FY 1987 budget resolution. The conferees recommended that the amount available nationally in FY 1987 be the same as was authorized in FY 1986--$741.2 million. We have administered the disability program within this budget without compromising quality or our commitment to implement the 1984 amendments effectively. We have managed our work and resources well.

A review of the history of DDS expenditures and productivity may be helpful in understanding our actions in FY 1987. SSA's Limitation on Administrative Expenses appropriation increased from $2.44 billion in FY 1980 to $3.84 billion in FY 1986, or 157 percent of the FY 1980 level. During the same period, the DDS obligations increased from $342 million to $755 million, or 221 percent of the FY 1980 level. Expressed in other terms, DDS obligations as a percentage of the LAE increased annually from 14.0 percent in FY 1980 to 19.6 percent in FY 1986.

However, DDS productivity during the same period decreased from FY 1980, when 9,373 full-time equivalent (FTE) employees processed approximately 2.3 million cases for a productivity of 248 case dispositions per workyear, to FY 1986, when it took 13,302 FTE employees to process approximately 2.2 million cases for a productivity of 168 case dispositions per workyear. This represents a 33-percent decrease in productivity during the same period as a 221-percent increase in funding. This can be seen by looking at attachment A, the bar chart entitled "Productivity."

Some of these differences can be explained by the need for more labor-intensive disability-case processing resulting from the 1980 and 1984 amendments. In addition, the staffing levels in the DDSs were maintained during the period of the CDR moratorium, which resulted in the DDSs becoming accustomed to an artificially reduced productivity level. The relationship between workyear usage and claims processed is illustrated at attachment B, the chart showing the workyears and workloads for each year since 1980.

On one hand, we do not believe the national productivity levels achieved prior to FY 1982 are within reach under present law and regulations. On the other hand, we do not believe that the requirements of the 1980 and 1984 amendments were so labor-intensive as to justify a permanent 33-percent drop in productivity.

We, therefore, set a workyear limitation of 12,529 workyears on the DDSs which resulted in a national target case dispositions per workyear of 195. This allowed us to live within the $741.2 million allocation and increase the national productivity level to a more stable and realistic level. FY 1987 was less resource-intensive than FY 1986 because training and extraordinary startup impacts resulting from implementation of the 1984 amendments were substantially completed in FY 1986. Our productivity target for 1987 was still 21 percent below the pre-1982 levels thus providing a margin to accommodate the changes in the program during the 1980s.

We did not reach our FY 1987 national target of 195 cases but our cumulative production for the year now stands at 192 and the average for the last 3 months is 201. This increase in FY 1987 productivity has been accomplished during the same period in which quality has shown a corresponding increase.

Our national productivity target for FY 1988 is 204.7 cases. Resources available to DDSs in FY 1988 are $754 million. All States received their FY 1988 planning amounts in August 1987. These levels reflect the continuation of our efforts to increase productivity in States that have been below the national target. This is, of course, subject to change based on final appropriations.

Another way to review the trends in DDS budgeting is cost per case. The Unit Cost per Case chart, at attachment C, shows the hefty increase in cost per case that occurred between 1980 and 1986.

STATE-BY-STATE RESOURCES

An increase in national productivity is not our only goal. During the 1980's significant differences in program administration developed from State to State.

Some States absorbed and incorporated program improvements and continued to maintain high accuracy rates and productivity. Other States spiraled downward in productivity consuming an ever greater proportion of the available resources. In FY 1986 State productivity ranged from 90 to 280 case dispositions per workyear. The extreme variation is inconsistent with the concept of a national disability program and could not be permitted to continue.

Therefore, SSA decided to strive for reestablishment of equity in the allocation of resources among the States. Equity could not be achieved in one year without an SSA-directed reduction in force (RIF) in low-producing States. We felt that this option would have an adverse impact on workload processing as well as a disastrous effect on many employees. We, instead, chose to return to equity over a several-year period.

We placed low-producing States under a hiring freeze until they achieved a case disposition per workyear of 195. This meant that our lowest producers were unable to hire throughout the year. The higher producing States were thus able to use a higher proportion of the available national resources. Resources were allocated to narrow the case disposition gap and we are moving in that direction.

In order to achieve SSA's goal of equity among States by the end of FY 1987, several low-producing States used innovative methods of reducing staff without a reduction in force, such as reassigning employees to other departments in the State. These States have proven their commitment to the efficient management of the program and to an equitable disposition of resources among the States.

REPROGRAMMING OF FUNDS DURING FY 1987

I do not want to give the impression we were dogmatic in our commitment to national productivity, equity, or in our application of the annual planning figures. Resource management of the DDSs is a dynamic process. Even a very low-producing DDS may need an exception to hire if it has a small staff and loses an employee with a critical skill.

The only way to assure fair and equitable national expectations is through effective communications with the DDSs.

I personally met with all the DDS administrators in Forums twice in FY 1987. In the first meeting in November 1986, we explained our expectations, while in the second meeting in May 1987, we provided a thorough progress review. During the year I visited 8 of our 10 regions to meet with DDS administrators singly or in small groups. I listened to specific problems and, if appropriate, took corrective action. If I did not take action I tried to assure that the administrator had a full understanding of my rationale. At the second meeting with all the DDS administrators, we also arranged private meetings between any concerned administrators and my top staff. We are planning another such meeting for early December.

As a result of these many communications, we were able to accommodate national expectations to State-specific problems. When actual workloads in a given State exceeded our projections as the year progressed, we allowed adjustments to be made including the hiring of additional staff where that was needed and justified. During January 1987 through May 1987, we approved approximately 20 requests for reprogramming of medical funds, additional workyears, or hiring exceptions. Each request was reviewed on its own merits and appropriate action was taken. Each was a result of an effective and widespread communications effort.

In June we completed our workload projections for FY 1988. We then took action with the fourth-quarter allowance advice to adjust workyears for FY 1987 so the States would enter FY 1988 at a level consistent with the workyear projections.

PROGRAM SIMPLIFICATION AND MANAGEMENT INITIATIVES

We have worked very actively with the States to simplify and streamline the disability determination process and will continue to do so. A special disability simplification workgroup consisting of disability staff from the regions, States, and central office met to examine each step of the claims process and developed initiatives to simplify the process through increased claimant involvement, improved coordination between field offices and DDSs, and better and faster development of medical evidence. Several program simplification initiatives have already been put in place:

- Encouraging SSA field offices to make the initial contact to obtain claimants' medical evidence of record, thus allowing the DDS to begin case development sooner.
- Emphasizing that SSA field offices must carefully develop the nondisability aspects of the disability claim before forwarding a case to the DDS for development. This saves time spent by the DDS in gathering unnecessary evidence in cases which would be denied on technical grounds.
- Improving the written rationale process to avoid duplication.
- Experimenting with having SSA field offices use claimant self-help interview forms and having claimants forward our requests for medical evidence to their doctors, where appropriate. This does not eliminate SSA's responsibility for assuring that adequate medical evidence is obtained. We use the claimant self-help initiative only when the claimant is able to complete the forms and make the requests.

We are also upgrading DDS automated systems. By having computer-generated information available earlier, SSA and DDS managers can identify and analyze financial and programmatic problems earlier and take swift remedial action. These systems also will allow us to better define and track productivity in the States. The result will allow us to give States earlier resource targets for their planning purposes, consistent with our goal of maintaining equitable distribution nationwide.

A recent major initiative is the creation of a Federal DDS which began operation a few months ago. This unit will provide SSA with the ability to assist DDSs in temporary or emergency situations or to take over a State's function if the State is no longer participating in the disability program. The Federal DDS will also improve program management by allowing us to better assess the consistency of our policy directives and the impact and effectiveness of new policies and procedures.

Before I conclude, Mr. Chairman, I would like to note that, in the Administration's FY 1988 legislative package, H.R. 2660 introduced by Mr. Archer on June 11, 1987, we have asked for permanent extension of the State compliance provision of the 1984 amendments. This provision, which expires on December 31, 1987, has timeframes and deadlines that permit the Secretary of Health and Human Services to respond swiftly and definitively to a State's failure to make disability determinations consistent with Federal law and guidelines. In this package, we have also asked for a 4-year extension of the statutory standard for evaluating pain and other symptoms. As you know, the statutory standard expired on December 31, 1986, and the extension would provide enough time to conduct studies and experiments recommended by the Commission on the Evaluation of Pain. I would ask that this subcommittee give prompt and favorable consideration to our request.

I also want to take this opportunity to say a few words about our efforts to encourage and support those disabled and blind beneficiaries who have the potential to return to work. On June 26, we published in the Federal Register a grants announcement of funding for a Research Demonstration Program. The announcement presents opportunities for funding demonstration projects covering a wide range of techniques for employing, training, or assisting these beneficiaries to begin and maintain substantial gainful employment. We are especially interested in innovative and progressive approaches which incorporate work incentives and result in more effective, successful job placements that can be generalized and replicated. We mailed copies of the announcement to every Member of Congress and interested outside organizations. We are now in the process of finalizing our decisions and notifying the applicants.

CONCLUSION

We know that Congress has long been concerned over the need for uniform disability program administration. In 1976, GAO studied the effectiveness of SSA's management of the DDSs and recommended that SSA adopt a stronger, more active management role to better ensure a uniform national disability determination process. To strengthen SSA management of the disability programs, Congress acted in 1980 to amend the Social Security Act to allow greater SSA control and oversight of the DDSs.

In 1985, after examining the effectiveness of the Federal-State relationship, GAO again concluded that much can be done to improve program administration within the present arrangement. Other GAO reports also have addressed this issue and cited the need to improve program management in such areas as: the consultative examination process; conduct of CDRs; the impact of face-to-face demonstration projects; and implementation of the 1984 amendments.

As you know, Mr. Chairman, GAO recently concluded a comprehensive review of SSA's management practices and identified a wide range of budgetary, operational, and performance management concerns. Commissioner Hardy has strongly endorsed the report and is moving aggressively to implement its recommendations.

Effective management in an era of fiscal constraint is a necessity. However, we expect no more of our State partners than we do of ourselves. We also must ensure that our own administrative funds are spent in the most cost-effective manner. I do expect the national budget picture, for both SSA and the DDSs, to remain tight.

SSA and the DDSs must continue to be respected as strong, well-managed organizations working together to assure quality service to disability claimants and beneficiaries. I know the DDSs share the same goals Commissioner Hardy has established for SSA:

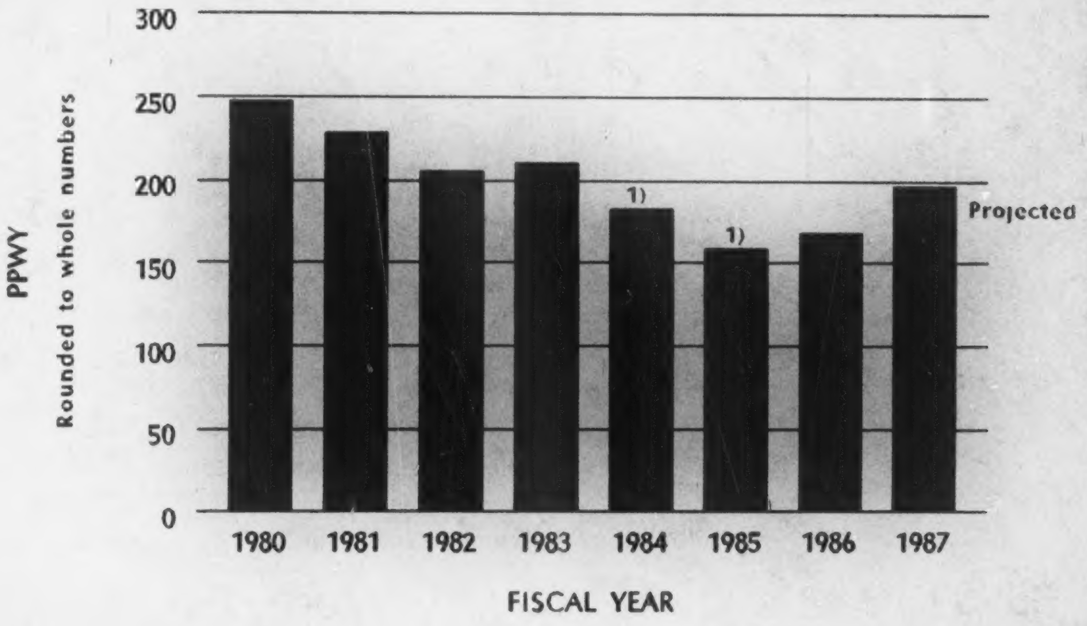
- o maintaining the fiscal integrity of Social Security programs;
- o providing the best service we know how;
- o using the best technology to administer Social Security programs;
- o educating the public so that people understand what they can expect from us; and
- o recognizing employees as important and valuable agency assets.

I intend to fully support those DDSs working to resolve operating and administrative problems and to work with them on our joint objectives of cost effectiveness, quality, and productivity. I also intend to stand firm in assuring the Congress that the disability program is administered in a nationally uniform manner, that State decisionmaking and management effectively implement the reforms made by the 1984 amendments, and that each State is provided with necessary funds, equitably allocated, to do a high quality job. I look forward to working with you and the States to achieve these goals.

Attachments

PRODUCTIVITY

National productivity for the State disability determination services is presented below. The productivity is presented in terms of production-per-workyear (PPWY). This represents total State clearances divided by total State paid WYs for the DDSs. The WYs are based upon a standardized 40-hour workweek.

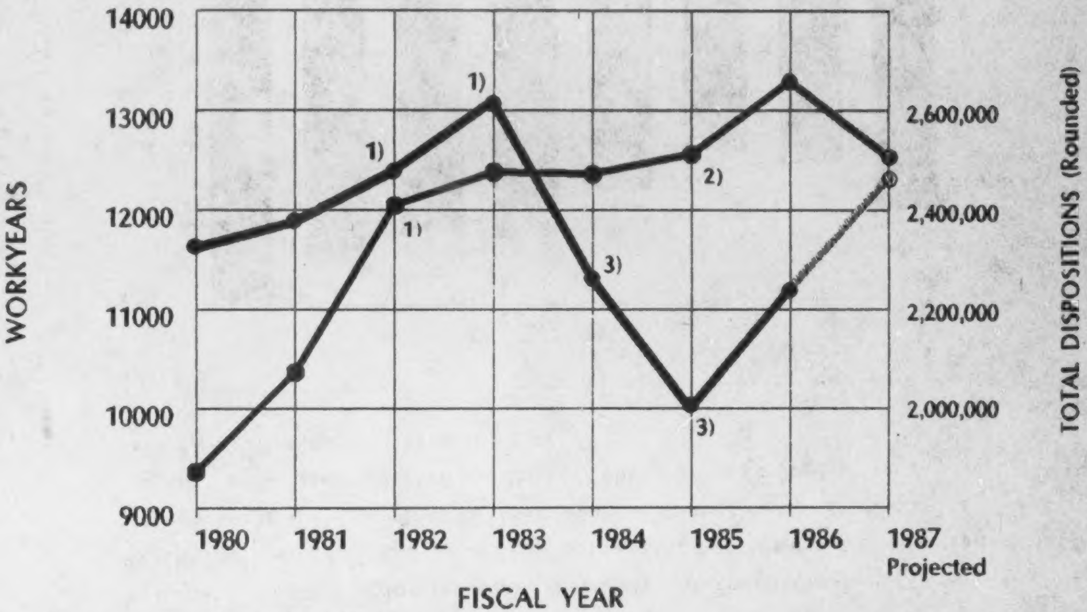


1) CDR moratorium years

ATTACHMENT B

WORKYEAR USAGE VS CLAIMS PROCESSED

National workyear (WY) levels for the State disability determination services (DDS) are presented below. All WY levels have been developed based upon a standardized 40 hour workweek. Total dispositions are presented for the DDSs nationally.

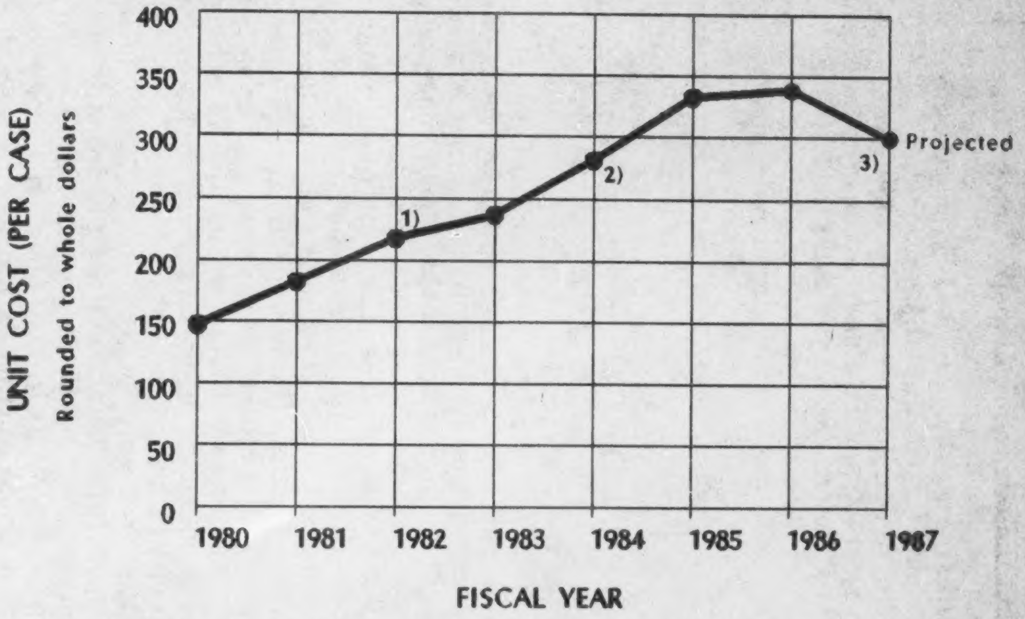


1) Expansion of CDR workload activity
2) 1984 Disability Amendment impact
3) CDR Moratorium

ATTACHMENT C

UNIT COST PER CASE

National unit cost data for the State disability determination services is presented below. It represents total State expenses divided by total State workload clearances.



1) Expansion of CDR processing

2) Establishment of disability hearings units (DHU)

3) FY 1987 budget, includes work simplification initiatives

Chairman **Jacobs**. Mr. Rust, when you speak of productivity, does that include the final disposition on appeal of the cases or just the number of cases processed at the State level?

Mr. **Rust**. Just through the DDS processing.

Chairman **Jacobs**. Just the processing?

Mr. **Rust**. Yes, just the DDS decision level.

Chairman **Jacobs**. So I assume that the quality of the productivity is not a factor in what you call productivity?

Mr. **Rust**. There are two mechanisms that we use to watch quality. Each DDS has a quality assurance unit of its own and is constantly watching the work that comes through, and hopefully taking corrective action within that DDS if problems develop.

Then we have a Federal review. We pull up samples of the cases and they are reviewed in the regional offices in units called disability quality branches, DQB. They review them. Then there is another subset of that done at the national level, to check on the consistency of the DQB review.

Chairman **Jacobs**. I am aware of that, but the question was are those analyses a part of the formula by which you determine the productivity figures? Do you include a measure of accuracy in the formula or do you simply divide the number of workers into the number of cases processed at the local level?

Mr. **Rust**. Yes, sir. The minimum quality standard is 90.6, and we work with them to get them as high as possible, and this is a factor we consider in determining the budgeted PPWY.

Chairman **Jacobs**. You use the familiar phrase in an era of fiscal restraint. You, of course, meant to say selective fiscal restraint, did you not, speaking for the administration? I believe some increases have been called for in certain areas this year, have they not, in the President's budget?

Mr. **Rust**. Yes, sir.

Chairman **Jacobs**. That is what I heard.

Thank you very much for your contribution to the record. I do not think there is any further question.

The first panel consists of American Federation of Government Employees and John Gage is the spokesperson who I presume will introduce his colleagues at the table.

I remind you again that we will follow the 5-minute rule. I hope no one takes personal offense, but when 5 minutes are up, so is that statement.

STATEMENT OF JOHN W. GAGE, NATIONAL VICE PRESIDENT, AND PRESIDENT OF LOCAL 1923, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Mr. **Gage**. Mr. Chairman, I am going to let Kitty Peddicord introduce our panel.

Ms. **Peddicord**. Mr. Chairman, my name is Kitty Peddicord. I am now employed with the American Federation of Government Employees. To my left is John Gage, who is national vice president of AFGE. He is also president of AFGE Local 1923.

To my right is Janice Cocquyt, who is a field representative from Akron, Ohio. To my far right is Ann Magenhan who is a benefit authorizer technical assistant with the office of disability operations.

Mr. GAGE. Mr. Chairman, we hope to give you a few different views from employees' perspective of the disability operation and what has been happening there and just how well we are adjudicating cases.

In spite of being a national vice president and a local vice president up at Social Security headquarters, I am also a disability examiner. I remember how strong in the training of the disability examiners and the pride that went through the workforce on making sure that beneficiaries received an absolutely fair and objective adjudication of their claims.

That emphasis on the quality and that each file that we review is a beneficiary, is a claimant out there, a potential beneficiary, has long since passed in the processing of disability cases. The disability examiner is probably at the bottom of the adjudicative process. All the court cases, all the administrative tugs and pulls on the program, changes made in Congress, all this kind of comes down on the disability examiner.

Many of these people have seen the changes in this program over the last 10 or 15 years. I had the opportunity to meet with them recently and to submit, along with my testimony, a survey of disability examiners which I think gives some real insight from the bottom level of the disability program.

We would like to make a couple recommendations. First of all, the consistency of the review and the wild fluctuations among States is something that our examiners kind of look on with disbelief because we think the problem could be cured very effectively.

Currently disability examiners who effectuate, who work the review of the State agencies, are housed in the Office of Disability Operations. They are two per module. A module is 100 employees working on various State accounts, spread all over a huge warehouse type of a building.

The set up defies consistency. Communications cannot be made to examiners. They are in outposts all over a very vast network of modules, some 45 of them.

The disability examiners have long complained about this, that it really hurts their effectiveness, that it does not allow them the type of communications and consistency to affect a good review. However, it seems that the real problem in separating the disability examiners and putting them in a better work environment is that their grade level, grade 11, supports the grade 13 mod manager and it is an artificial type of alignment that really hurts the program and consistency.

All through our surveys that we are submitting to you, that is probably the number one recommendation from the employees, that the current set up in modules simply defies any type of consistency on a central office review.

Our second recommendation is to restore credibility to the adjudicative process, that we really think the State agencies should be federalized. We think there would be more control, more consistency of adjudication, more equity for beneficiaries across the country.

And lastly, our recommendation is that Social Security should be made an independent agency. I think just the administrative tugs and pulls on this program through the last several years has really frustrated a lot of our people who are sincerely dedicated to the program and we think that the independent agency would allow us to perform our work in a more objective and a more fair manner.

I hope you take into consideration some of the recommendations that will be made from some of our other panelists.

Thanks.

[The statement of Mr. Gage follows:]

STATEMENT OF JOHN W. GAGE, NATIONAL VICE PRESIDENT, AND PRESIDENT OF LOCAL 1923, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

The disability program has been politicized for many years. Adjudications based more upon the political climate than upon fair, objective, and consistent criteria have served to undermine the credibility of the Social Security program with beneficiaries and the general public. Changes in the decisionmaking criteria and process, made not through Congress but by internal agency and administrative vehicles, have also added to the disarray of the adjudication process.

I'd like to speak to you today as a representative of the disability examiners within SSA. I am a disability examiner, and I am also President of our Local union at Social Security headquarters.

Since the onset of the 5% review process in the early 1970's, there has been a very clear deterioration in the quality of the adjudicative process. Emphasis that previously reinforced the integrity of the adjudicative process shifted to wholesale allowances and to denials depending upon the most recent lawsuit or political expedite.

The Headquarters and State agency disability examiners are the first tier of the adjudicative process. I think our perspective is valuable to the committee because not only have we experienced the heaving and groaning of the disability program, but we have some recommendations to make for the overall improvement of the program.

To start at the bottom, the disability examiners in Headquarters are distributed two per work module. There are 45 modules in the Office of Disability Operations staffed by 100 employees each. Within modules, which are little payment-oriented factories, the entire disability process is represented. The managerial staff is very process conscious. The majority of managers have little or no experience in the adjudicative process or the function of the disability examiners. The communications necessary to keep the staff informed of constant policy and procedural changes, to cross-train, and to share information cannot be maintained by keeping the decisionmaking process spread out over 45 locations as it is in the module structure. Quality and case handling reasons support an organizational grouping of the examiners; however, the modules were established by grade structure to support the module manager GS-13 position. Keeping the examiners in the modules maintains the grade structure. But shouldn't program concernsbe our main priority?

Removing disability examiners from the modules and consolidating them is a small recommendation but one that will improve the process of disability decisionmaking. Attached are the results of the survey of disability examiners which provide more information about the need for some basic restructuring.

Disability examiners have a sense of disbelief concerning the state by state interpretations of disability criteria. Allowance/denial rates fluctuate widely from State to State. The authority of an overall SSA review of Disability Determination Section (DDS) decisions has been severely curtailed. However, the present morass of inconsistency clearly shows the need for a strong SSA review to assure fairness and objectivity in the disability process.

Staffing cuts and case production quotas have turned an integrate part of the disability process into a cursory, paper shuffling routine. Bad decisions made in the past are being exacerbated today. Short circuiting a strong disability reviewing function has contributed, as much as anything, to the general deterioration of the program. Revitalizing a strong Federal review and restoring credibility in the adjudicative process is something that should have been done yesterday and now must be done today.

Federalizing State DDS sections would advance consistency greatly. Performing better in the adjudicative process with sound reviews and consistent applications is surely better than adjudicating in the rising tide of beneficiary litigation.

Giving the claimant a timely and thorough adjudication up front is better business than the insidious adverse process that has developed.

Finally, the Social Security Administration needs to be an independent agency. Establishing the agency as described in this subcommittee's bill will remove several layers of bureaucratic influence over the program and at least contribute to de-politicizing this most essential social program.

Even though a current environment of frustration and demoralization is prevalent among disability examiners hope remains that the job for which we were hired to do will be revitalized to take advantage of their expertise and sincere dedication to the program.

madessa

By: - - - -

FIRST FEDERAL CHAPTER OF NADE

87 = Total

		YES	NO	OTHER Unanswered, Unsure, etc.
1.	A. HAVE YOU WORKED AS A DISABILITY EXAMINER, DISABILITY CONSULTANT OR RECON DISABILITY EXAMINER FOR AT LEAST ONE YEAR?	(86)	(1)	
	B. HAVE YOU DONE SUCH WORK FOR THE PAST YEAR?	(79)	(8)	
	C. HAVE YOU WORKED AS AN EXAMINER (DE,DEC or RE) FOR MORE THAN SEVEN YEARS AND WORKED IN BOTH A FUNCTIONAL (DIC/DCE/OA) AND THE CURRENT MODULAR ORGANIZATIONAL STRUCTURE OF ODO?	(54)	(33)	
2.	DO YOU FEEL THAT CURRENT EXAMINERS (DE,DEC & RE) HAVE GOOD MORALE AND MOTIVATION?	(6)	(77)	4
3.	DO YOU FEEL THAT THE EXAMINER (DE,DEC or RE) IS CONSIDERED AS A VALUABLE PROFESSIONAL WHOSE FUNCTION IS AT LEAST AS IMPORTANT AS THAT OF AN AUTHORIZER AND VITAL TO THE FUTURE OF ODO?	(22)	(63)	2
4.	DO YOU FIND THAT THE ODO MANAGEMENT STRUCTURE OF THE MODULES IS RECEPTIVE TO THE NEEDS OF DISABILITY REVIEW?	(9)	(71)	7
5.	DO YOU THINK THAT THERE IS A LACK OF EXAMINERS IN MANAGEMENT AND THAT QUALITY OF ADJUDICATION SUFFERS AS A DIRECT RESULT?	(64)	(20)	3
6.	DO YOU ENJOY YOUR WORK AS A DISABILITY EXAMINER (OR DID YOU ENJOY IT WHEN YOU WERE AN EXAMINER)?	(61)	(21)	5
7.	ARE THERE ANY STEPS THAT COULD BE TAKEN TO MAKE DISABILITY EXAMINING WORK MORE SATISFYING? COMMENTS:	(66)	(6)	15
8.	DO YOU FEEL MEETING QUALITY AND PRODUCTION GOALS AND DOING SPECIAL ASSIGNMENTS ARE REWARDING FOR EXAMINERS IN TERMS OF PROMOTION?	(5)	(74)	8
9.	DOES THE QUADO PROCESS RESULT IN IMPROVEMENT IN PERFORMANCE OR CLARIFICATION OF PROCEDURE FOR EXAMINERS?	(13)	(67)	7
10.	A. FOR PURPOSES OF OPTIMAL DISABILITY ADJUDICATION, DO YOU PREFER THE CURRENT MODULAR STRUCTURE OF ODO OVER A FUNCTIONAL STRUCTURE (SUCH AS OA)?	(20)	(61)	6
	B. DOES THE MODULAR STRUCTURE AFFECT YOUR WORK? ANY COMMENTS (SUCH AS HOW TO IMPROVE MODULAR STRUCTURE):	(47)	(29)	11

87 = TOTAL

		YES	NO	OTHER
11.	DO THE COUNTERPART MEETINGS PROVIDE ADEQUATE COMMUNICATION BETWEEN EXAMINERS IN DIFFERENT DIVISIONS AND OFFSET ANY DISADVANTAGE OF DISPERSING EXAMINERS INTO 45 MODULES AND 15 RECON STAFFS?	(14)	(65)	8
12.	A. ARE YOU PROVIDED ADEQUATE PROCEDURE AND REFERENCE MATERIAL?	(39)	(41)	7
	B. ARE YOU PROVIDED A SUITABLE WORK STATION?	(45)	(41)	1
	C. HAVE YOU VISITED THE 7TH FLOOR REFERENCE ROOM AT LEAST TWICE IN THE PAST YEAR?	(16)	(71)	
	D. HAVE YOU USED THE 2ND FLOOR MEDICAL LIBRARY IN PAST YR?	(9)	(78)	
13.	ARE YOU UP-TO-DATE ON THE LATEST PROCEDURE & POLICY?	(44)	(30)	13
14.	DO YOU HAVE CURRENT REFERENCE BOOKS (MERCK'S MANUAL, DORLAND'S MEDICAL DICTIONARY, PHYSICIAN'S DESK REF., ICD MANUALS, DOT, ETC.) NEEDED BY THE EXAMINER? COMMENTS:	(40)	(44)	3
15.	DO YOU HAVE ANY SIGNIFICANT PROBLEMS WITH PROCEDURE RELATING TO MAJOR ACTIONS (EPE, SSI, CAPS, ACID, JURISDICTION, ETC.) COMMENTS:	(50)	(33)	4
16.	DO YOU HAVE ADEQUATE REFRESHER TRAINING AND TRAINING RESOURCES AND ACCESS TO RESPONSIVE POLICY REFERENCE SERVICES?	(14)	(64)	9
17.	A. HAVE YOU MADE A PERSONAL VISIT WITH A MEDICAL STAFF PHYSICIAN TO DISCUSS A CASE IN THE PAST TWO YEARS?	(25)	(52)	
	B. HAVE YOU MADE A PERSONAL VISIT WITH A VOCATIONAL SPECIALIST TO DISCUSS A CASE IN THE PAST TWO YEARS?	(2)	(85)	
18.	ARE EXAMINERS IN ODO/OA COMPARABLE IN DECISION MAKING AND CONSISTENCY AND ARE THEY AS TRAINED AND AS INFORMED AS EXAMINERS IN THE FIELD (STATE DDS, REGION, PC)?	(14)	(47)	26
19.	SHOULD THE CENTRAL OFFICE DISABILITY EXAMINER BE THE MOST EXPERT EXAMINING COMPONENT IN THE DECISION MAKING PROCESS?	(78)	(4)	5
20.	ARE DISABILITY EXAMINERS PREPARED FOR RESUMPTION OF THE CONTINUING DISEBILITY REVIEW PROCESS?	(6)	(74)	7
21.	DO YOU EXPECT THE CONCEPT OF DETERMINING MEDICAL IMPROVEMENT WILL HAVE ANY SIGNIFICENT EFFECT ON THE TIME NEEDED TO REVIEW CASES?	(78)	(7)	2
22.	HAVE THE CONTENT OF CLAIMS FOLDERS (ALJ REARRANGEMENT OF LEFT AND RIGHT INSIDES, BULKY IMPACC OUTPUT, LACK OF FORMAL 833 DECISIONS ON MORATORIUMS AND COURT REMANDS, ETC.) AND THE CASE CONTROL OF CLAIMS SIGNIFICANTLY CHANGED IN THE PAST TWO YEARS TO THE EXTENT OF EFFECTING PRODUCTION [illegible]	(75)	(6)	6

87 = Total

		YES	NO	OTHER
23.	DO YOU EXPECT THAT MANY OF THE CLAIMS THAT HAVE BEEN CEASED AND REINSTATED WILL BE CEASED AGAIN WHEN THE CDR PROCESS RESUMES?	(47)	(30)	10

24. WHAT DO YOU CONSIDER THE GREATEST PROBLEM FOR IMPROVING THE DISABILITY EXAMINER PROCESS IN CENTRAL OFFICE?

____

____

		IMPROVE	SUFFER	
25. A.	DO YOU THINK THAT THE QUALITY OF THE FEDERAL REVIEW PROCESS OR REVIEW INTEGRITY WOULD IMPROVE OR SUFFER IF ODO EXAMINERS WERE REMOVED FROM THE MODULES TO ONE BRANCH IN EACH DIVISION?	(66)	(8)	13
B.	IF ODO EXAMINERS WERE REMOVED FROM THE MODULES TO THE OFFICE OF ASSESSMENT AND OA GIVEN FULL CENTRAL OFFICE REVIEW RESPONSIBILITIES?	(48)	(20)	19

ANY COMMENTS: ______________________________

____

____

THANK YOU FOR YOUR VALUABLE TIME AND EFFORT SPENT IN COMPLETING THIS QUESTIONNAIRE!

P.S.

IF YOU WANT TO HELP DISABILITY EXAMINERS FURTHER, HELP NADE.

PLEASE JOIN....NADESSA! IT IS YOUR PROFESSIONAL ORGANIZATION.

BE A PROFESSIONAL.

JOIN

National Association of Disability Examiners madessa

By: ____

FIRST FEDERAL CHAPTER OF NADE

1. Have you worked as a disability examiner or recon disability examiner for at least one year? Yes [24] No [–] OTHER 1
for the past year? Yes [18] No [2] 5

2. Have you worked as an examiner for more than seven years and worked in both functional (DIC/DCE/OA) and modular organizational structure? Yes [14] No [11]
If Yes, which do you consider more desirable and why?
[11] FUNCTIONAL [3] MODULE WHY: ____
OTHER: 11
____
____

3. Do you feel examiners have good morale and motivation?
Yes ☐ No [19] Unsure [6]

4. Do you feel that the disability examiner is respected as a valuable professional whose function is at least as important as that of authorizer and vital to the future of ODO/OA?
Yes [1] No [19] Unsure [5]

5. Do you find that ☐ ODO/☐ OA management structure is receptive to the needs of disability examiners?
Yes ☐ No [21] Unsure [4]

6. Do you think there is a lack of examiners in management and that quality of adjudication suffers as a direct result?
Yes [19] No [1] Unsure [5]

7. Does the modular structure affect your work as a disability examiner? Yes $\boxed{17}$ No $\boxed{6}$ Enhances $\boxed{-}$ Deters $\boxed{17}$ Of no significant consequence $\boxed{1}$ Any comments (such as how to improve structure): ____________
OTHER: 2

____

____

8. Do you enjoy your work as a disability examiner? Yes $\boxed{17}$ No $\boxed{4}$ OTHER: 4

9. Are there any steps that could be taken to make your work more satisfying? Yes $\boxed{20}$ No $\boxed{2}$ Comments:
OTHER: 3

____

____

10. Do you feel meeting quality and production goals and processing special assignments in timely fashion is rewarding for disability examiners in the promotional policy at ODO? Yes $\boxed{3}$ No $\boxed{15}$ Unsure $\boxed{7}$

11. Does the QUADO process result in improvement in performanc or clarification of procedure for disability examiners? Yes $\boxed{4}$ No $\boxed{16}$ Unsure $\boxed{5}$

12. Do counterpart meetings or any other meeting formats seem to provide adequate communicating of common problems and concerns between examiners in different divisions? Yes $\boxed{4}$ No $\boxed{16}$ Unsure $\boxed{5}$

13. Are you provided adequate procedure, reference materials and suitable work station? Yes 7 No 16 Unsure 2

14. Are you up-to-date on the latest procedure and policy and do you have current reference books (ie. Merck's manual, Dorland's medical dictionary, PDR, ICD, DOT, etc)? Yes 9 No 9 Unsure 7 Comments: ____________

15. Do you have any significant problems with procedure relating to major actions (EPE, SSI, CAPS, Mental Impairment, Jurisdiction, etc)? Yes 14 No 9 Comments:
OTHER: 2

16. Do you have adequate refresher training and training resources and access to vocational and medical consultants and responsive policy reference services?
Yes 4 No 21 Unsure ☐

17. Have you ever made personal contact with a medical staff physician or vocational specialist? Yes 20 If so, how often? ____________ No 4 If not, why?
OTHER: 1

18. Are examiners in ODO/OA comparable in decision making and consistency and are they as trained and informed as examiners in the field (DDS, Regions, PC)?
Yes ☐ No 14 Unsure 11

19. Should the central office disability examiner be the most expert examining component in the decision making process?
Yes 22 No 1 Unsure 2

20. Are disability examiners prepared for resumption of the CDR process?
Yes 1 No 18 Unsure 6 (Comments may be added on last page!)

21. Do you expect the concept of determining medical improvement will have any significant effect on the time needed to review cases? Yes 24 No ☐ Unsure 1

22. Have the content of claims folders (ALJ rearrangement of left and right insides, bulky IMPACC output, lack of formal 833 decisions on moratoriums and court remands etc.) and the case control of claims significantly changed in the past 2 years to the extent of effecting production when the CDR process resumes?
Yes 21 No ☐ Unsure 4

23. Do you expect that ~~many~~ of the cases that have been ceased and reinstated will be ceased again when the CDR process resumes?
Yes 8 No 11 Why? ____________
OTHER: 6
____

24. What do you consider the greatest problem for improving disability examiner process in central office?
____

25. Do you think that the quality of the federal review process or review integrity would improve or suffer if ODO examiners were removed from the modules to one Branch in each Division? Improve ☐ 18 Suffer ☐ 1
OTHER: 6
....if ODO examiners were removed from the modules to the Office of Assessment and OA given full central office review responsibilities? Improve ☐ 15 Suffer ☐ 2
OTHER: 8
Other ____________________

Any comments: ____________________

Thank you for your valuable time and effort spent in completing this questionnaire.

P.S.

IF YOU WANT TO HELP DISABILITY EXAMINERS FURTHER HELP NADE. PLEASE JOIN.... MADESSA.

Comments From July 1 Survey

Caution: Some of these comments are more than candid, even angered and frustrated expressions. They serve to illustrate the diversity of feelings among examiners. Such comments can also be sensitive and should be kept within house.

1. Have you worked as a disability examiner or recon disability examiner for at least one year? Yes [24] No [–] Other 1
for the past year? Yes [18] No [2] 5

Other indicates unsure or unanswered. Possibly a consultant, analyst, manager...
One questionnaire had a comment: "17 Years."

2. Have you worked as an examiner for more than seven years and worked in both functional (DIC/DCE/OA) and moduler organizational structure? Yes [14] No [11]
If Yes, which do you consider more desirable and why?
[11] Functional [3] Module Why: ____________
Other [III] = Answered No To First Part

Why Functional:

- "There is no uniformity and/or consistency in decisions, instructions, procedures, no evaluation in spite of QUADO's manufactured figures."
- "DE's position in the Mod is merely to justify the grade structure for the Mod manager. We need a centralization of DEs where instructions can be given as needed – need for support of positions, etc."
- "We are in essence functional now and operating as we did prior to Modularization.. i.e. Individual production quotas and accuracy quotas."
- "The module did not accomplish the desired efficiency in claims handling."
- "I consider functional better for DE as too much time is consumed in mod by AMC function. However, I think it is an advantage for the Mod BAs and CAs to have DEs in the Mod."
- "Easier to control procedure, distribute instructions, train personnel."

Why Functional (continued):

"We were with people with whom we had a job in common. We could learn from one another and discuss common difficulties. Information could be dessemnated more easily. There was more uniformity in the way cases were being processed."

"More DE interaction; higher profile; greater potential for consistency."

"OA - more and closer relationships with MCS (OME), out of production mentality."

"All examiners essentially did the functional role in the same way. Under modularization, there appears to be at least 45 ways things are being done / cases worked. I recall no project as a module examiner which ended up with the same procedure under which it started. Changes were major, instructions tardy or not received."

Why Module:

"Module - For variety of activities."

"The Modules concept is an excellent idea but in our setting has created an air of extreme competitiveness rather then teamwork. It seems that quality and efficiency are translated into figures and quotas rather than the product itself."

"A revised modular form, not the current form. Current modular structure mirrors the status of claims folders, especially since 1975 - containing increasingly overcomplicated or insufficient material - disorganized, misassociated and almost out of control. But with

Why Module (continued):

some much needed modification can still be the best available way to go. DEs need more centralization and support."

3. Do you feel examiners have good morale and motivation?
Yes ☐ No $\boxed{19}$ Unsure $\boxed{6}$

"I believe he or she has good motivation but is grossly disillusioned resulting in bad morale."

"Absolutely not."

"There appears to be some frustration and dissatisfaction. But I suspect that the changing civil service structure may have a key role in this. It is an individual thing mostly..."

4. Do you feel that the disability examiner is respected as a valuable professional whose function is at least as important as that of authorizer and vital to the future of ODO/OA?
Yes $\boxed{1}$ No $\boxed{19}$ Unsure $\boxed{5}$

"Absolutely not."

"Mods are payment oriented - not evaluation..."

"No - Due to the current Administration's Review and Approval process."

"Respected? .... By whom? - Does this question imply that an authorizer is regarded as a "valuable professional"?"

"I dont quite understand this question."

5. Do you find that ☐ ODO/☐ OA management structure is receptive to the needs of disability examiners? Yes ☐ No [21] Unsure [4]

"Could hardly care less. Some with consultant background are more indifferent because they accepted the Adm. attitude toward examiners."

"Of course not."

"They appear to be running about third behind the BAs and CAs." (unsure)

6. Do you think there is a lack of examiners in management and that quality of adjudication suffers as a direct result? Yes [19] No [1] Unsure [5]

"The 2-week briefing provided managers is just that - a briefing!"

"Should read lack of managers with disability examiner background or experience."

7. Does the modular structure affect your work as a disability examiner? Yes [17] No [6] Enhances [-] Deters [17] OTHER: 2 Of no significant consequence [1] Any comments (such as how to improve structure): ______

"Remove DE from the clerical functions involving folder location, WCAPs backlogs. TOE codes, coding forms (3094, 3500, etc.) for computer input, etc. DEs are charged with a very important review of disability issues and ought not be concerned with these mundane matters that are irrelevant to the immediate issue."

How To Improve Modular Structure (continued):

"The Mod structure voided any consideration of the examiner staff in the promotional structure."

"Mainly with respect to inaccessibility to mod staff personnel."

"Structure doesn't provide for management who is DE experienced."

"No consultant immediately available."

"Examiners should be located together for uniformity and consistency of decision

"Go back to functional setup with knowledgable manager - not some file clerk that was promoted to manager of DEs and REs."

"Too much time given to RMC (records maintenance clerk) function to reduce time in mod location."

"Management has no regard for DEs. Only BAs and CAs are significant

"Put all examiners in a common location. I have different concentration among others (CA, BA, Recovery, RMC and Supervisor) running around disturbing the work I do."

"I have to go a great distance to the location of consultants."

"Seating Recon and Examiners together would be helpful."

"Smaller groups of examiners do not enhance the learning process. Not as many brains to pick. Take us out of the Mods!"

"I am actually in a very quiet area with all necessary materials accessible and will perform to the best of my ability wherever."

"Go back to functional."

"Get out of the production mentality. Close liaison with MCS/Policy - at least co-equal status with OA in this area."

"I feel it is more the Mgmt. attitudes towards the DEs' work than the

How To Improve Modular Structure (continued):

organizational "structure" itself. However, within structure, attitudes become a more sensitive issue/factor to deal with."

8. Do you enjoy your work as a disability examiner?
Yes 17 No 4 OTHER: 4

"But not to the same degree of past years when the position was recognized."

"Sometimes."

"There is too much emphasis on the numbers game in determining if an individual is doing a satisfactory job. While production standards are certainly needed here, doing the job right the first time so as not to have to go back and correct someone else's errors is of equal or greater importance."

"Unsure."

"Yes - Work. But not people of other positions."

"I feel lonely and left out."

"Sometimes. Only from a medical standpoint - when I learn things concerning disease processes, medical procedures, etc."

9. Are there any steps that could be taken to make your work more satisfying? Yes 20 No 2 Comments:
OTHER: 3

"The concept of "merit pay" for disability examiners was discussed and promised as long as about 10 years ago, but never materialized as it has for management persons."

Steps To Make Work More Satisfying (continued):

"Production standards are ridiculous. Examiners just do not fit in with the modular process."

"More decision making. Easier access to med staff."

"Being treated professionally and having the opportunity to exercise more judgement would be plusses; less OA scrutiny would also be a plus."

"More training and discussion is needed for the frequent changes in procedure and policy."

"DEs should be treated as professionals, should be given proper respect for their expertise and judgement, should be considered as quality reviewers/analysts - not simply clerks charged with certain production quotas."

"Put examiners in an organization such as the DDS where they can have fuller access to MCS, procedures, each other, etc."

"Co-equal status with OA."

"More uniformity in translation and application of procedures and less nit-picking in the Quality Review process. Reduction of cumbersome form completion and elimination of some asinine functions - such as mandatory documentation of SSI files which aren't even our jurisdiction.

"Work for a manager who understands DE work."

"Access to consultant, time for consulting, access to medical staff."

"Training - better written procedures - 65 Series / Poms - details to staff functions - improved ACID.."

"Better communication with management. More meetings, briefings, etc."

Steps To Make Work More Satisfying (continued):

"Consolidate the DEs in one location, apart from the noise of other workers, including clerical control people."

"More promotional opportunities, more awards, more respect. Let us work as professionals without being hindered by nonsensical production and accuracy requirements."

"Shove the production standards and emphasize quality."

"Upgrade the professional status of our job, give us a more quiet atmosphere, encourage quality work, reduce pressure on production."

"As above - get out of the production mentality. Closer liaison with MCS/Policy - at least co-equal status with OA in this area."

10. Do you feel meeting quality and production goals and processing special assignments in timely fashion is rewarding for disability examiners in the promotional policy at ODO?
Yes [3] No [15] Unsure [7]

"I don't know exactly what you mean." (Unsure)
"???" (Unsure)

"It may be. I haven't been the recipient of any consideration for promotions, details, etc." (Unsure)

"Few promotional opportunities available."

11. Does the QUADO process result in improvement in performance or clarification of procedure for disability examiners?
Yes [4] No [16] Unsure [5]

QUADO process (continued):

"Serves more to confuse."

"Sometimes, but generally deficiencies are of a picayune nature." (Unsure)

"If done properly and desseminated." (Yes)

"It can but most QUADO errors are for picky things."

"It gives management their silly figures and status."

"Being attached to the Merit pay of management as is, it lessens the effectiveness of QUADO." (Unsure)

12. Do counterpart meetings or any other meeting formats seem to provide adequate communicating of common problems and concerns between examiners in different divisions? Yes 4 No 16 Unsure 5

"No. Because the examiner needs to be informed. Now, material is just dumped on your desk and you have 1/2 hour per week to read and assimilate it."

"Non-existent for DEs. Too infrequent for Consultants."

"More discussion and time to read questions and answers."

"Should be monthly rather than quarterly. Does not resolve different processing methods or procedures within Divisions."

"Examiners are not usually privileged to attend and information, when dessiminated, is not always timely. Also, really complex issues rarely resolved."

"Persons conducting meeting generally are so far removed from situation, they can approach it only authoratatively, not reasonably."

"We don't have any counterpart meetings."

13. Are you provided adequate procedure, reference materials and suitable work station? Yes 7 No 16 Unsure 2

"Adequate procedure, reference materials - Yes, Suitable work station, No"
"Need more quiet atmosphere to work."
"Too many sources - RC, POMS, Supplements, ES, Word-of-Mouth..."
"No telephone furnished for consultants."
"Procedural instructions not always received timely. Very little time allowed to review and file when received."
"My work station is terribly noisy."
"Much procedure late in arriving if received at all. Procedure seems to be changed weekly, with many changes for the sake of change or just superflous."
"Noisy. No phone. When calling DO, sometimes have to use Secretary's phone and she is typing."
"Distribution is untimely. Too many ES & CCRs exist."

14. Are you up-to-date on the latest procedure and policy and do you have current reference books (ie. Merck's manual, Dorland's medical dictionary, PDR, ICD, DOT, etc)? Yes 9 No 9 Unsure 7 Comments: __________

"My books are 18 years old."
"The POMS is a mess and a disgrace. Let us go back to the DOM, CM and DISM - Hooray for nostalgia!"

Uptodate References (continued):

"Procedure is distributed but we cannot take sufficient time to read it thoroughly or coordinate it."

"I am sure these are available but generally procedures are not evenly distributed. Often, special instructions are learned about week after release and usually not learned about through channels but from friend in another mod."

"I have a 10th edition Merck's - No PDR or DOT."

"Are you serious?"

"I do not have the latest editions but I have the books."

15. Do you have any significant problems with procedure relating to major actions (EPE, SSI, CAPS, Mental Impairment, Jurisdiction, etc)? Yes 14 No 9 Comments:
OTHER: 2

"I feel that procedure should be simplified, outlined, etc. so as to facilitate the use of information in processing the cases."

"No - But the constant state of flux and voluminous references dealing with the same subject item detracts from production."

"EPE... CAPS"

"All ERS procedures are vague or undefined. Jurisdiction and routing procedures are inadequate. ACID procedures are awful."

"Yes.... EPE"

"I am puzzled by the significance of the Quarterlys which replace the Informational Digest and prior precedent files and guides as well as the recently distributed Regulations...."

Problems With Procedure (continued):

"The DDS's were the first to see and review the new proposed mental impairment listings. The DDSs were the first to see and review other proposed legislation pertaining to the disability program...."

"The new POMS stinks. As I said before, we get 1 hour per week to file, read and assimilate new material. Not enough. Need more training time and more effective communication."

"Procedures both written and oral are unclear, ambiguous and lacking in consisten

"SSI Knowledge is inadequate. When EPE was instituted, training of BAs, DE and Ing. Spec. should have been coordinated."

"Procedures are received "piece meal" Through associates rather than channels- someplace the chain breaks - possibly at its weakest link: Mods."

"POMS procedures are incomplete, obscure and confusing regarding EPE, preparation of The SSA 3500. There is a constant and ongoing battle between DEs and Recon DEs regarding jurisdiction."

"Arrangement of the POMS is cumbersome and confusing. To obtain CAPS instructions, the DE has to muddle through much instruction intended for other components."

"SSI, CAPS"

"EPE"

"Some procedures are ambiguous. There is a need for a more comprehensive reference

"Training not provided to all DEs at same time."

"No - Other than my personal feeling that too many 833s are utilized during The EPE adjud. process and the aforementioned redundancy of some required SSI documentation."

16. Do you have adequate refresher training and training resources and access to vocational and medical consultants and responsive policy reference services?
Yes 4 No 21 Unsure ☐

"We have a lot of training. The quality leaves a lot to be desired. Vocational consultants are needed in ODO also."

"The overlay of OSS is too heavy and their bag is bulls and control."

17. Have you ever made personal contact with a medical staff physician or vocational specialist? Yes 20 If so, how often? ______________ No 4 If not, why?
OTHER: 1

Yes: "Twice" "Twice"
"Very rarely."
"About three times."
"Rarely. It is not apparent that this contact is encouraged."
"A few times a year"
"Not often to MCS. Vocational Specialist - Never!"
"About 3 seperate occasions for each in my 14 years as DE"
"Biannual"
"6 times a year"
"On about 2 occasions under leadership of a consultant."
"Very infrequently.."

No: "Simply just not provided for."
"It is discouraged."
"All contact in written form."
"Recon examiners are doing very little substantive work now and therefore do not need much of the above."

Contact With MCS/VS (continued)

"2-3 times during a 4 year period"

"Before Moratorium, about 3 times a month."

"About 2-3 times. We are not encouraged to seek med staff assistance"

"As needed for a significant number of times."

"3 times"

"Many times."

"As I wish. But I have filed two grievances and an EEO to defend my right to "wander the halls," etc."

18. Are examiners in ODO/OA comperable in decision making and consistency and are they as trained and informed as examiners in The field (DDS, Region, PC)?

Yes ☐ No $\boxed{14}$ Unsure $\boxed{11}$

"They have ongoing training sessions."

"In general, the educational requirements for the DDS examiners are much higher than for SSA."

"I don't feel that our training, for the job I am doing, is adequat It also appears that the Admin. does not think so either."

"Field examiners have voc. specialist and college training in many states."

"Are you serious? We cannot or do not adjudicate (at this time)

"I believe examiners in the field have more ongoing medical and vocational training. Evidently, SSA management also feels this way as recruits from DDSs appear to be promoted or assigned as analysts, policy specialists, etc. in much greater proportion to their number than are examiners who are ODO trained."

19. Should the central office disability examiner be the most expert examining component in the decision making process?
Yes 22 No 1 Unsure 2

"We should all be a uniform team in a decision making process and not required to beat one another over the head with deficiencies, etc."

"I believe that we should be at least as knowledgeable as the DDS examiners."

"In order to perform a quality review, a reviewer must have at least as much training as reviewee."

"At least just as proficient."

"Yes - But we do not examine, we are reviewing examiners."

20. Are disability examiners prepared for resumption of the CDR process?
Yes 1 No 18 Unsure 6

"Need training."

"Hopefully by 9/85 or 10/85 when it goes live."

"Training needed on new regulations when recieved."

"Have recieved no substantive training or briefing on any new procedures."

"There has not been any formal training for years."

"Additional training needed."

"For production - Yes, For substance - No"

"We fell into our current predictament because of a long period of neglect and casual training of central office examiners. The "super" examiners of OA are no better off - It's incredible."

21. Do you expect the concept of determining medical improvement will have any significant effect on the time needed to review cases? Yes [24] No ☐ Unsure [1]

"More time required because of an indepth comparision of both current and prior evidence required."

"All medical evidence will have to be reviewed in detail and related forms will require more entries."

"Requires careful evaluation of prior med. evidence and current."

"Yes - But it will make no difference in ODO."

"We may need a course on how to speed read folders!"

22. Have the content of claims folders (ALJ rearrangement of left and right insides, bulky IMPACC output, lack of formal 833 decisions on moratoriums and court remands etc.) and the case control of claims significantly changed in the past 2 years to the extent of effecting production when the CDR process resumes?
Yes [31] No ☐ Unsure [4]

"There is an epidemic of multiple folders which makes processing difficult. Case control system is antique."

"Trying to decipher a file after an ALJ has reviewed it is a time consuming experience and storage of cassettes in file mutilates and disassembles material."

"Perhaps we need to keep medical in a seperate folder."

Content Effecting Production (continued):

"I believe management should be made aware of the terrible condition of many of the folders before they are sent out again."

"ALJs should have to maintain their tapes and to resequence all folder materials."

"There are so many listings and so much paper that the resumption of CDRs will require hours just determining the reason for the listing, etc. In addition, entirely too many memos, etc."

"Only these two - bulky IMPACC output and lack of formal 833 decisions on moratoriums and court remands - have significantly changed or increased during the past two years.

23. Do you expect that many of the cases that have been ceased and reinstated will be ceased again when the CDR process resumes?

Yes 8 No 11 Why? ____________
OTHER: 6

"No - Fear."

"Volume of review will cause "following path of least resistence" - favorable decisions."

"Depends on type of impairment - Mental impairment, No - Others, Yes"

"The new medical improvement standard will make it difficult to cease a case

"Medical improvement standard will probably result in more continuances."

"It's my feeling that most cases were ceased properly."

Ceased Again (continued):

"Class action requirements are very liberal."

"I believe most examiners say - Why - No one cares but me."

"Yes - Because reinstatement was based on a technical process. Future review will demonstrate medical improvement even under the new legislation. Many beneficiaries returned to work (SGA)"

"No - Because of the difficulty of determining significant medical improvemen

"Not really sure. Depends on how lax or stringent new regulations are."

"I don't Know. It depends on The political climate."

"Apparently The taxpayer will be stuck with bad allowances. which would not have been allowed in The first instance if all allowances had been reviewed. Nothing from nothing leaves nothing. How does claimant improve from no impairment."

"I think a lot of the mental impairment cessations were wrong but most of the physical impairment cessations were right. Medical improvement standard may get in The way of ceasing people who should be ceased however."

"Guidelines are not rigid and too much emphasis is placed on inability to secure jobs. The intent of the program was changed to be more like unemployment compensation SSI is too lenient"

"There was a lack of professionalisim. It seemed to me that the word was "cease a certain number, continue The rest" - political and certainly not in The best interest of the claimant and harmful to The administration."

"To attempt to cease is too time consuming in ODO production mind."

Ceased Again (continued):

"Many of the initial CDR cessations were done because the person's condition was expected to improve."

24. What do you consider the greatest problem for improving disability examiner process in central office?

"The lack of effective supervision. Management positions lack examiner background. How can they appraise my performance? As always, management is only interested in figures. Quality adjudication and morale is of no consequence."

"There should be more comparability and consistency in decision making. Also, raising production standards to an unrealistic and unreasonable level can only adversely affect quality of work on cases and servic. to the claimants we serve as quality of work is sacrificed for speed."

"I think more and better training is needed and quality should be the only prime goal."

"The greatest problem is uniformity of examiners.

"The Mod and Management's attitude toward Examiners. The courts should have made Management stop and look at the process. When you have a staff that is used to glorify management only, you cannot expect uniformity and consistency simply because Congress and The Courts ruled it so. Morale flows downstream as does respect, appreciation and other good qualities not upstream from examiners to management."

"Management/Administration's attitude about DEs"

"More managers with DE experience and centralization of all DEs"

"Production"

"Too many opinions. No uniformity."

"Uniformity and Management"

"Lack of uniformity among Central Office - Field components. Lack of more specialized training in medical areas (i.e. training on deciphering eKgs and other medical evidence, tests, etc.)"

"Lack of concern on Management's part for DE's function." Therefore, little attention, if any, is given to the position. For years (since the MOD structure) we have gone on unnoticed. I wonder if it is too late to turn things around."

"Management is fighting us all the way. They just don't understand our jobs and buck at any suggestion of changing the status quo."

"Attitudes of Management. The lack of ongoing training. The lack of a review system which stresses the positive aspects of how a case is handled rather than the negative."

"Too many people and offices writing too many changes which do nothing except justify their own existence. Those writers seem to know very little about DEs"

"Morale. Respect for the examiner's opinion."

"Attrition has reduced the staff to a point that will make it impossible to process the number of cases anticipated. Even if new people are "trained", they will not be prepared until a year out of training class. A significant amount of training is done on the job. How are the current examiners to train the new people and do their jobs?"

"Management"

25. Do you think that the quality of The federal review process or review integrity would improve or suffer if ODO examiners were removed from The modules to one Branch in each Division? Improve $\boxed{18}$ Suffer $\boxed{1}$ OTHER: 6
....if ODO examiners were removed from The modules to the Office of Assessment and OA given full central office review responsibilities? Improve $\boxed{15}$ Suffer $\boxed{2}$ OTHER: 8
Other ________________________________

"I don't think ODO examiners should be a part of OA. They should be a separate operational unit in The structure. OA should remain a "watchdog."

"It appears that if ODO examiners are removed from the modules, the quality of the federal review process will suffer by examiners not being able to communicate effectively with and work in the same area as other components involved in the disability process (such as BAs, CAs, DSI, etc)"

"Unsure of OA" x 4

"Before CDR process is restarted, extensive reviews should be given in mental impairment area, EPE, SGA areas, medical improvement criteria under new law, etc."

"This would improve only because examiners would be together. All the figures that support the uniformity of decisions should be examined in light of recent court decisions. If judges can see this and the examiner can see it - one can only conclude that management is not looking or they would also see it."

"OA stresses quality. ODO stresses production. Quality is more efficient in the long run. ODO rewards the person who turns over a case 3 X for case counts when action could be completed with one turnover.

"DEs would be given the prestige enjoyed by OA (deservedly so). It would be a more professional atmosphere away from the hustle and interruptions of the Module. DEs ought not to be concerne with lost folders, checking backlogs, WCAPs and, most of all, production quotas."

"Management is not really concerned with the disability examiner func We are just a thorn in their side. I have been in grade for 18+ y and I am very bitter and resentful that my talent and knowledge in the disability field have not been used to the full. I have seen th position of DE deteriorate to the low ebb it is today. I believe something should be done, but I don't believe any improvement will be accomplished until management is changed. Get the "Devi out of management and put in people who know what they are doi i.e. who have the background to feel for others. I do not see this ever coming to pass in my lifetime. It is sad that in the end the claimant (who pays our salary) suffers."

"Separating the medical review from non-medical aspects should vastl improve the disability process."

"No significant difference either way because of the underlying politic environment."

"I strenuously object to the DE position being filled with what appears t be malcontent misfits or social blessings to incompetency."

" It would enhance access to expertise."

"Production standards as established rush the disability process to the point when production becomes more important than quality or knowledge. Also, I was quite disappointed to find a real lack of the study of medicinie and disease when I became a DE."

"I believe that if OA and ODO were united in goals, production standards, etc. instead of being pitted against one another, it would be better for everyone. Perhaps this would be achievied if ODO examiners were made a part of OA. In my view, the attitudes of management are our chief obstacles. They must begin giving us some professional status or morale will become so low that the atmosphere will be intolerable."

"Just as all examiners are centralized in field and OA, so should we in ODO be."

STATEMENT OF ALMA DOLIN, DISABILITY CONSULTANT, OFFICE OF DISABILITY OPERATIONS, SOCIAL SECURITY ADMINISTRATION, AS PRESENTED BY KITTY PEDDICORD, ON BEHALF OF THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Ms. PEDDICORD. Mr. Chairman, as I said before, my name is Kitty Peddicord. Alma Dolin was unable to attend today and asked that I present her testimony. So when I am speaking, I am meaning Alma.

Chairman JACOBS. Why don't you just say Alma?

Ms. PEDDICORD. In referring to the testimony.

Alma has worked for the Social Security Administration since September of 1958 when the disability function moved to Baltimore. Since August 1966, Alma has been involved in the examining of individuals' claims for disability insurance benefits. She is a GS-12 disability consultant and has been since February 1979.

She is making this appeal today because she is concerned about the disability program. We have a national disability program that touches the lives of many citizens, excluding the thousands of employees, and should be treated with respect. Alma has seen the time when very few cases went before the Federal Judicial System because the public had confidence in the integrity of SSA decisions.

If SSA history during the past few years tell us anything, it is that the public no longer respects the decisions of SSA. She believes it behooves us to examine the disability process in an effort to restore the public confidence, financial stability, decisional integrity and legal compliance.

Examples of some of the situations she believes have contributed to the deterioration of the program are as follows: One, the regulations 404.1520(a) for instance require that disability consultants prepare a decisional rationale for each case. However, the Administration has deemed that the regulations and the POMS making this requirement can be disregarded.

Two, regulations 404.1592 and POMS reference indicates if an individual earns $75 a month it can represent an effort to engage in trial work, but the Administration has determined that earnings less than $1,000 will not be investigated. This $1,000 could clearly represent nine months of trial work allowed by the above references.

Three, diaries that have been established by the POMS references and regulations are routinely disregarded. This has been accomplished by instructing the technician to reenter a diary that is long past due or to destroy the alerts.

Four, the disability examiner completes a review and prepares a notice to the claimant. The disability consultant reviews the actions, including the notice. After the notice is typed, a random selection is made to have a second review of the notice after typing the consultant who previously reviewed the notice for content. Now he must review it again for clerical completion and complete attached form. This is a waste of time of the consultant's expertise.

This represents only a few examples of the administration's disregard for the national disability program and the laws and regulations that govern it. The Administration will surely plead expediency but it is, in fact, poor management. It is amazing that so many of the managers have very little training in the evaluation of disability claims and thus can manage only with production figures as evidenced by Ms. Hardy's comments in setting goals for 1987 that she wanted to increase productivity.

The organization of the Office of Disability Operations and the review process of disability claims almost prohibits any consistency and/or uniformity in the disability decisions. It also requires that managers, even to the GS-13 level, spend much of their time tracking folders. Much energy is spent in making sure a case is processed in a predetermined time frame instead of assuring the integrity of the decision.

Reducing staff figures is commendable but not when it reduces service and impasses professional rape in the disability evaluation process.

I will be happy to supply the subcommittee with documented evidence if requested.

Thank you for allowing me to testify.

At this point, I would like the documents that were entered for the record to be entered.

[Attachments to the statement of Ms. Dolin follow:]

SSA PROGRAM CIRCULAR

General Series

ADR

No. 86-300 OFFICE OF DISABILITY OPERATIONS Date: OCT 02 1986

SUBJECT: Simplified Alternate Decision Review (ADR) Rationale

AUDIENCE: RECONE, DEC, DE, and DS

REFERENCE: POMS DI 40530.410, POMS DI 28091ff and GS 86-130

Effective October 1, 1986, decision rationales as outlined in DI 28090ff, will not be required in continuances and cessations. However, a brief statement will be required to explain certain situations, if not explained elsewhere in the file.

Decision review (DR) rationales are similar in most respects to continuing disability review (CDR) rationales, and should be simplified or eliminated to the same degree as CDR rationales.

There are special issues in DR cases, however, which are not ordinarily of concern in CDR cases and which must be documented in some manner. Therefore, the rationale (SSA-4268) part of the favorable replacement determination in an ADR case need contain only the following elements.

1. Show the comparison point decision (CPD) date and the replacement date (RD).
2. Briefly discuss any inconsistencies in the file which appear material to the decision. Evidence which implies or suggests the possibility of a different decision at the RD is considered material. For example, the denial of a subsequent claim may suggest that disability did not continue, but if the evidence does not show MI at the RD, a favorable replacement determination would not be inconsistent with the later denial. The denial, however, could show subsequent improvement requiring a current CDR.

PUBLISHED BY OPERATIONS SUPPORT STAFF /Disability and Special Projects Group

FOR INFORMATION CONTACT: Your Program Analysts

SSA Pub. No. 54-076

DESTRUCTION DATE:
Indefinite

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration

TITLE II

esl

CESSATION OR CONTINUANCE OF DISABILITY OR BLINDNESS DETERMINATION AND TRANSMITTAL

1.A. SOCIAL SECURITY NUMBER: 426 60 0335 BIC: A

No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing public law 96-265.

1.B. TYPE CLAIM: ☒ DIB ☐ FZ ☐ DWB ☐ CDB ☐ [illegible] ☐ [illegible]

1.C. OTHER ENTITLEMENT: ☐ TITLE II ☐ TITLE XVI

2.A. NAME OF PAYEE (IF ANY)

3. WE'S NAME (IF CDB OR DWB CLAIM)

B. NAME OF DISABLED OR BLIND INDIVIDUAL: Archie D. Fai r Jr.

4. DATE OF BIRTH: 03/08/34

5. DATE DISABILITY BEGAN: 12/24/76

C. ADDRESS:
1919 E. 55th St., Apt. 2110
Cleveland, OH 44103

6. DO ADDRESS:
1240 E. 9th St., Rm 793
Cleveland, OH 44199

7. DO CODE: 388 DDS CODE: 360

8. A. ☒ INITIAL B. ☐ RECON C. ☐ RECON DHU D. ☐ ALJ HEARING E. ☐ APPEALS COUNCIL F. ☐ U.S. DISTRICT COURT G. ☐ REOPENING

9. UPON CONSIDERATION OF ALL FACTS, IT IS DETERMINED: ☒ DISABILITY ☐ IMPAIRMENT SEVERITY (EPE MEDICAL REVIEW ONLY)

		MONTH	YEAR
X	A. CONTINUES		
	B. CEASED		
	C. PERIOD OF DISABILITY TERMINATED AT THE CLOSE OF THE LAST DAY OF		
	D. EPE BEGIN MONTH		
	E. EPE REINSTATEMENT ALLOWED		
	F. EPE REINSTATEMENT DENIED	▨	▨
	G. EPE SUSP. AFTER REINSTATEMENT		
	H. EPE BENEFIT TERMINATION MONTH		

		MONTH	YEAR
	I. 301 CASE	▨	▨
	J. BLINDNESS	▨	▨
	(1) CONTINUES		
	BEGAN		
	(a) DISABLED FOR CASH PURPOSES SINCE		
	(b) NOT DISABLED FOR CASH BENEFIT PURPOSES SINCE		
	(2) CEASED		
	(3) CEASED		
	OTHER IMPAIRMENT BEGAN		

10. BASIS FOR DETERMINATION: A. ☒ MEDICAL/MEDICAL VOC. B. ☐ WORK—NO IRWE C. ☐ WORK—IRWE INVOLVED D. ☐ OTHER (Explain in Item 24.)

11. REASON FOR CESSATION CODE:

12. REASON FOR CONTINUANCE CODE: 34 MEDICAL LIST NO.

13. ☒ CHECK IF ATTACHING A CONTINUATION SHEET.

14. ☐ CHECK IF VOCATIONAL RULE MET. CITE RULE

15. VOCATIONAL BACKGROUND

16. OCC. YEARS

17. EDUC. YEARS

18. SPECIAL USE

19. VR ACTION: A. ☐ SC IN B. ☒ SC OUT C. ☐ PREV. REF. D. ☐ RE-REF.

20. WHY REVIEW WAS MADE—CODE: 04

21. PRIMARY DIAGNOSIS: Schizophrenia, paranoid type;~ BODY SYSTEM: 12 CODE NO.: 2953

22. SECONDARY DIAGNOSIS: None established; CODE NO.: 0000

23. DIARY

A. TYPE	B. MONTH	B. YEAR	C. REASON
MRN	09	90	3

24. REMARKS

MULTIPLE IMPAIRMENTS CONSIDERED
☐ 24.A. COMBINED MULTIPLE NONSEVERE—SEVERE
☐ 24.B. COMBINED MULTIPLE NONSEVERE—NONSEVERE

25. DISABILITY EXAMINER/SUPERVISOR: XX/0448/DB

26. DATE: 9-1-87

27. PHYSICIAN OR MEDICAL SPEC. SIGNATURE

28. DATE: 9/2/87

29. LETTER/PARAGRAPH NUMBER: DDS/DL L1013, 6

30. PHYSICIAN OR MEDICAL SPEC. NAME (STAMP, PRINT, OR TYPE): JERRY G. LIEPACK, MD

30A. SPEC. CODE: 12

31. SSA REPRESENTATIVE

32. SSA CODE

33. DATE

34. LIST NUMBER	A.	B.	C.	D.	E.	F.

35. FOLDER SENT TO: ODO 9/3/87

FORM SSA-833-U5 (8-86)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration

DISABILITY DETERMINATION RATIONALE

Name of Claimant	W/E's Name (if CDB or DWB)	SSN	TYPE OF CLAIM
ARCHIE D. FAIR JR.		426-60-0335	DIB

As of 11/82 the claimant was continued for disability due to paranoid schizophrenia. Current evidence shows this condition continues and significant improvement has not been shown.

CLAIMS REP (DO-SGA DETERM)	Date					

(Initial and Date)

Disability Examiner DDS	Date	Review Physician DDS	Date	Disability Examiner SSA	Date	Disability Examiner SSA	Date
0448	9/7/87						

Form SSA-4268-U4 (1-85)

1. FOLDER COPY

entitlement should be terminated.

NOTE: *Although pension postings will be reflected on the folder alert documents, they are not included in the posted summary earnings amount.*

The output from the CDR enforcement operation is standardized to accommodate output data from several different earnings-related operations. Under this operation, the data will be reflected on an 8 1/2" × 11" document. Computer tapes containing the output materials will be mailed to the Program Service Center (PSC) maintaining jurisdiction of the claims folder, except for material for the Office of Disability Operation (ODO) and the International Program Service Center (INTPSC), which will be printed at Central Office and delivered to those processing centers.

The CDR enforcement operation will produce various alert categories to the processing center maintaining jurisdiction of the claim. To facilitate the control of this workload a Continuing Disability Review Origination (CDIO) date will be established on the Master Beneficiary Record (MBR) for follow-up on certain alert legends. (See the chart below for identification of those alert legends). The annotated CDIO is established as the current operation month (COM) and year the CDR enforcement operation runs. In addition, a Reason for Disability Review (RDI) code of "C" (enforcement) will be annotated to the MBR.

The output documents will be forwarded to disability examiners for resolution. Definition of the various alert legends, resultant MBR update annotations and action required for each are reflected below:

Legend	***Definition***	***Systems Generated MBR Update***	***Action Required***
Possible Statutory Blind	Work data is present for statutorily blind beneficiary.	RDI/CDIO	See DI 40510.045 C. and DI 40510.050 B.7.
BIC D, E or W - No Trial Work Period	Widows and disabled widows are not entitled to a trial work period prior to December 1980.	None	This legend will apply only for earnings posted earlier than December 1980. See DI 13010.130.
Medical Reexamination Diary Due (MMYY)	Posted earnings alert is received and a Medical improvement expected (MIE) diary is present on the MBR.	RDI/CDIO	See DI 40505.020.

The following alerts are generated because wage postings are in excess of $1000.00.

No Disability Investigation Data on the MBR as of Enforcement Year	Posted earnings are received that could not be screened against the MBR since no DIB INV data is present on the MBR.	RDI/CDIO	See DI 40510.045 through DI 40510.050.
CDR in Progress - Current Work on MBR	A continuing disability review is in prograss and the work and earnings alerted may be prior to the CWS/TWPS dates recorded on the MBR.	None	See DI 40510.045 D. and DI 40510.050.
CDR in Progress - Prior Work on MBR	A continuing disability review is in progress and the posted earnings are either before the PWAS or after the PWAE dates on the MBR.	None	See DI 40510.045 D. and DI 40510.050.
CDR in Progress - No Work on MBR.	A continuing disability review is in progress and the PWAS and TWPS dates are not recorded on the MBR.	None	See DI 40510.045 D. and DI 40510.050.

CONTINUATION

Process the ACID followup alerts as indicated on the chart below.

FLI	1-5 Months	6-11 Months	12 Months or More
MODS	DESTROY	Process as described in SM 00625.006C5.e.1)a) to locate the folder and process for the CDR.	Process as described in SM 00625.006C5.e.1)a) to locate the folder and process for the CDR.
Dormant	DESTROY	Process as described in SM 00625.006C5.e.1)a) to locate the folder and process for the CDR.	Process as described in SM 00625.006C5.e.1)a) to locate the folder and process for the CDR.
EXTERNAL	DESTROY	Request that the folder be returned to ODO. When the folder returns to ODO associate the alert and process the case for the CDR.	Request that the folder be returned to ODO. When the folder returns to ODO associate the alert and process the case for the CDR.
OTHERS (DO/DDS)	DESTROY	DESTROY	Process in accordance with SM 00625.006C5.e.1)b) to forward the alerts.

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CONTINUATION

a. there is an SSA-833 in file, indicating that a DR has been conducted, cancel the listing and develop the work activity issue in the normal manner; or

b. there isn't an SSA-833 in file to indicate that a DR has been conducted, forward the case to the DDS on an SSA-847-U2. Refer to General Series Program Circulars GS 85-156 dated 11/25/85 items II.D. or E. and GS 86-64 dated 03/18/86 items II.E. or V.C. (as appropriate) for information regarding the use of the SSA-847-U2. Be sure to alert the DDS to the fact that the case not only involves the decision review (DR) that must be done per POMS DI 28045.001ff, but that earnings are reflected for 1985 or 1986 (as appropriate), which must be developed by the field office (FO) if the DR is a continuance. Since there isn't an area for remarks on the SSA-847-U2, it will be necessary to write any remarks on a report of contact or other folder document.

F. Entering or reentering information via the SSA-3500 on CDR enforcement cases after completion of CDR enforcement actions

Since a CDIE on the MBR will suppress CDR enforcement alerts for earnings up through the year of the CDIE, do not enter a CDIE unless the case has been developed. Therefore, if you "NAN" the CDR enforcement alert without developing the earnings, do not enter a CDIE but "# out" the CDIO and RDI and update the MRED info, if necessary, as shown below. If you develop the earnings, do not "# out" the CDIO and RDI but enter a CDIE and update the MRED info, if necessary, as shown below.

Category of Diary	Status of Diary on MBR	Action to Take
1) MIP √ medical improvement possible	a) Unscheduled (no Diary on MBR)	Do not enter MRED
	b) Past Due	Enter COM plus at least 2 months
	c) Future	Re-enter same MRED

NO. 87-247 OFFICE OF DISABILITY OPERATIONS ADVANCED COPY DATE:

CONTINUATION

2) MIE Medical improvement expected	a) Past Due	Enter COM plus at least 2 months
	b) Future	Re-enter same MRED
3) MINE	a) Past Due	Enter COM plus 36 months
	b) Future (COM plus at least 36 months)	Re-enter same MRED
	c) Future (COM plus less than 36 months)	Enter COM plus 36 months
4) "042" (5 year Diary)	a) Past Due	*Enter COM plus 36 months
	b) Future (COM plus at least 36 months)	*Re-enter same MRED
	c) Future (COM plus less than 36 months)	*Enter COM plus 36 months

*Always use MDR of 5 for "042" cases.

Chairman JACOBS. Thank you very much.

STATEMENT OF JANICE COCQUYT, CLAIMS REPRESENTATIVE, SOCIAL SECURITY ADMINISTRATION, ON BEHALF OF THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Ms. COCQUYT. Mr. Chairman and committee members, my name is Janice Cocquyt. I have just completed my 14th year as a claims representative for Social Security in the Akron, Ohio, District. I have worked as both a title II Social Security, and title XVI SSI claims representative and have always received excellent evaluations as well as a high quality increase in 1978 and cash awards in 1984 and 1987.

For the past 4 years, I have been assigned to a title XVI initial claims unit in the downtown Akron, Ohio office.

My purpose in testifying today is to bring to your attention a few of the many abuses being committed in the name of productivity, which is just a guise for staffing cuts and budget reductions.

Social Security employees are constantly exhorted to work smarter and harder with fewer people and more meager resources. Service to the public has always been a cornerstone of the Social Security Administration. Our reputation has been one of timely and accurate processing of claims and post entitlement actions, accompanied by prompt and courteous treatment.

In recent years, the revolving door to the Commissioner's office, the lack of independent agency status for Social Security, and the current policy of doing more with less has seriously eroded our ability to provide the service the public pays for and deserves.

These factors have also frustrated and demoralized the caring and committed employees who staff the Social Security offices around the country. Unfortunately the disabled, who are the most in need of our help, are the least able to cope with the changes of recent years and are the most disadvantaged by these changes.

I have spoken to claims representatives and claims examiners in both Ohio and Indiana in the past few weeks about these changes, and I would like to tell you what I have learned from them and from my own experiences as a claims representative.

On October 2, 1987, I spoke to a claims examiner with several years experience working in the Ohio DDS. He confirmed that staffing cuts and budget restrictions are wreaking havoc there, as they are in the district offices. He stated that their budget has been cut $1.4 million for this fiscal year and would probably be reduced again for the next fiscal year.

In addition, no claims examiners have been hired since June of 1986 and at least 10 have left the agency in the past 12 months. None who left were replaced and a State and Federal hiring freeze remains in effect. Some days, various units in the DDS have no clerical help due to absences or the mailroom staff is gone so mail, including disability claims, are not picked up or delivered, causing delays in claims processing.

Expanded duties and reduced staffing have increased processing time about 10 days in the past 12 months according to the examiner to whom I spoke. It is now about 60 to 65 days per claim, although some claims can take up to 6 months to complete. The average work load per claims examiner has increased, even though the total number of claims received by the DDS has decreased slightly.

At one time, reconsideration reviewers had smaller workloads and were able to help the claims examiners with backlogs. They no longer have time to do this since their numbers have been cut as well.

The Ohio DDS is not able to process all of the claims it receives, so some are being sent to the Michigan DDS for adjudication. At first, only reconsiderations were sent to Michigan, but in the past 6 months initial claims have been added. The examiner with whom I spoke was unable to find out how many claims were sent or what percentage of total receipts for the Ohio DDS were sent. However, in reviewing my own claims workload, I estimate that 10 to 20 percent of the decisions come from the Michigan DDS.

Although guidelines for disability decisions are Federal, the allowance rate does vary from State to State. If the Michigan denial rate is higher, then Ohio residents are being disadvantaged by having their claims processed in Michigan.

The Indiana DDS, on the other hand, seems to have found a novel solution to the staffing dilemma. On October 1, 1987, I spoke to a claims representative in a large Indiana office who told me that their DDS staffing is based on processing time, so low processing time means more staff.

The DDS is making about 75 percent of the SSI claims presumptive disabilities. This usually means that the physical or mental disability is so severe that one can assume that the claim will be approved. The district office can then initiate up to three months of SSI payments to the claimants while the claim is still in process and awaiting the final decision.

DDS processing time stops at the point this decision is made and it is usually made within 2 to 3 weeks of the receipt of the claim by the DDS. Therefore, 75 percent of their SSI claims have DDS processing time of only 14 to 28 days, instead of the usual 60 to 65 days, which lowers their overall time.

[The prepared statement of Ms. Cocquyt follows:]

TESTIMONY
OF
JANICE COCQUYT
CLAIMS REPRESENTATIVE
SOCIAL SECURITY ADMINISTRATION

Mr. Chairman and Committee Members:

My name is Janice Cocquyt. I have just completed my fourteenth year as a claims representative for Social Security in the Akron, Ohio, district. I have worked as both a Title II (SSA) and Title XVI (SSI) claims representative and have always received excellent evaluations, as well as a high quality increase in 1978 and cash awards in 1984 and 1987. For the past four years I have been assigned to a Title XVI initial claims unit in the downtown Akron, Ohio, office.

My purpose in testifying today is to bring to your attention a few of the many abuses being committed in the name of productivity, which is just a guise for staffing cuts and budget reductions. Social Security employees are constantly exhorted to "work smarter and harder" with fewer people and more meager resources. Service to the public has always been a cornerstone of the Social Security Administration. Our reputation has been one of timely and accurate processing of claims and post entitlement actions, accompanied by prompt and courteous treatment. In recent years, the revolving door to the Commissioner's office, the lack of independent agency status for Social Security, and the current policy of doing more with less has seriously eroded our ability to provide the service the public pays for and deserves. These factors have also frustrated and demoralized the caring and committed employees who staff the Social Security offices around the country. Unfortunately, the disabled, who are the most in need of our help, are the least able to cope with the changes of recent years and are the most disadvantaged by these changes.

I have spoken to claims representatives and claims examiners in both Ohio and Indiana in the past few weeks about these changes, and I would like to tell you what I have learned from them and from my own experiences as a claims representative.

On 10/2/87, I spoke to a claims examiner with several years experience working in the Ohio DDS. He confirmed that staffing cuts and budget restrictions are wreaking havoc there, as they are in the district offices. He stated that their budget has been cut $1.4 million for this fiscal year, and would probably be reduced again for the next fiscal year. In addition, no claims examiners have been hired since June, 1986, and at least ten have left the agency in the past twelve months. None who left were replaced, and a state and federal hiring freeze remains in effect. Some days, various units in the DDS have no clerical help due to absences or mailroom staff is gone, so mail, including disability claims, are not picked up or delivered, causing delays in claims processing.

Until recently, there were six or seven nurses on the DDS staff who took medical evidence by telephone from doctors in order to speed the processing of disability claims. The nurses also spoke to third party sources to complete lengthy reports on claimants with mental disabilities. This development is now required under recently issued guidelines for psychiatric cases. The contracts of these nurses were not renewed because of staffing restrictions. The claims examiners, already overburdened by current workloads, have been forced to pick up these additional duties, causing even more delays in claims processing.

Expanded duties and reduced staffing has increased processing time about ten days in the past twelve months, according to the examiner to whom I spoke. It is now about 60 to 65 days per claim, although some claims can take up to six months to complete. The average workload per claims examiner has increased, even though the total number of claims received by DDS has decreased slightly. At one time, reconsideration reviewers had smaller workloads and were able to help the claims examiners with backlogs. They no longer have time to do this since their numbers have been cut as well.

The Ohio DDS is not able to process all of the claims it receives, so some are being sent to the Michigan DDS for adjudication. At first, only reconsiderations were sent to Michigan, but in the past six months initial claims were added. The examiner with whom I spoke was unable to find out how many claims were being sent or what percentage of total receipts for the Ohio DDS were sent. However, in reviewing my own claims workload, I estimate that ten to twenty percent of the decisions come from the Michigan DDS. Although the guidelines for disability decisions are federal, the allowance rate varies from state to state. If the Michigan denial rate is higher, then Ohio residents are being disadvantaged by having their claims processed in Michigan.

The Indiana DDS, on the other hand, seems to have found a novel solution to the staffing dilemma. On 10/1/87, I spoke to a claims representative in a large Indiana office who told me that their DDS staffing is based on processing time, so low processing time means more staff. The DDS is making about 75% of the SSI claims presumptive disabilities. This usually means that the physical or mental disability is so severe that one can assume that the claim will be approved. The district office can then initiate up to three months of SSI payments to the claimant while the claim is still in process and awaiting a final decision. DDS processing time stops at the point this decision is made, and it is usually made within two to three weeks of the receipt of the claim by the DDS. Therefore, 75% of their SSI claims have DDS processing time of only fourteen to 28 days instead of the usual 60 to 65 days, which lowers their overall time and results in more staff. Unfortunately, most of these claims are returned from the DDS with final decisions of denial because the medical evidence does not support an approval. The three months of benefits already paid to the claimant are not considered an overpayment and cannot be recovered from the claimant.

If 1,000 SSI claims are received by the DDS in a month and 75% or 750 are designated as presumptive by the

DDS, then as much as $765,000 could be paid out over a three month period (750 x $340 x 3). If only 25% of the 750 are finally approved, which is an average approval rate, then 75% of the presumptive benefits paid out, or $573,750, would have been paid out erroneously just so the DDS could improve its processing time and get the staff it needs to do the job! It doesn't make sense to save money with one hand and throw it away with the other.

All of the offices I contacted in both Indiana and Ohio are plagued by the same problems caused by staffing and budget cuts. These include delayed processing of continuing disability review cases (CDR's), poor telephone and in-office service due to a severe shortage of clerical staff, and the transference of responsibility for the completion of disability forms from SSA employees to the claimant.

The CDR interview is lengthy and development is often time consuming. These include cases with the possibility of medical recovery and those in which the claimant has returned to work. The latter can cause large overpayments if not processed timely. The majority of these cases are then shipped to the DDS for a reevaluation of the claimant's medical condition. Backlogs of these cases exist in almost every office. A claims representative from a large Ohio office told me on 9/30/87 that a decision was made in his office at the end of 1986, not to process the CDRs for several months because of staff shortages and the pending installation of and training for the new CMP-FOSE computer system. Since the weekly workload report does not ask for the age of CDRs (over 60 or 90 days old), just the total number pending, they were not considered a priority workload. That office still has about 80 CDRs to complete, some dating back to mid 1986.

Even if the CDRs are processed promptly by the district office, shipping them to the DDS may be prohibited because the DDS does not have the staff to handle them and initial claims, too. At the beginning of July, 1987, offices in Ohio were directed to stop shipping CDRs to the DDS. This ban was lifted at the end of August, but we are currently limited to a quota of eight per office per week to be sent to DDS. There are 104 now pending in my office, and additional batches of receipts are expected in November, 1987, and February, 1988. It is difficult to imagine how we will ever get rid of them all at the rate of only eight per week, or how many overpayments may be accumulating.

The shortage of clerical help is a nationwide problem. An office in Indiana with a staff of 75 to 80 people, has only three full time clericals and two part time clericals. The claims representatives in that office spend an average of four hours per day doing their own clerical work. This is just another example of the practice of false economy. SSA is paying GS-9 and GS-10 employees to do GS-3 and GS-4 clerical work. It is obvious that the installation of the CMP-FOSE system has not done away with the need for clerical help as we were told it would.

The most serious consequence of the staff cuts is the transference of the responsibility for completion of disability forms from SSA employees to the claimant. Chicago regional instructions were issued in January, 1987, which directed claims representatives to give the Disability Report form (3368), to the claimant to complete and return to the office, even if the claimant came into the office to file a claim. I know from personal experience that about 75% of the SSI claims taken in the Akron office are for people with mental disabilities. These people are supposed to be excluded from this procedure, but I have seen some claims representatives give the forms to them anyway, just to save time. A claims representative in a large Ohio office told me on 10/1/87, that employees in his office had never been told there were any exlusions from this procedure, so forms were given to everyone. This could happen more and more often as staff shrinks and workload pressures increase. The claimants least able to protect their own interests, the mentally ill and illiterate or semi-literate, are the most affected by this policy. Where is the "safety net" to catch these people? In the past, the SSA employees were the safety net. We don't have time to do that any more because we're too busy working "smarter and harder".

Thank you for giving me the opportunity to present these issues of concern to myself and many other Social Security employees.

Janice Cocquyt

Janice Cocquyt
10/6/87

Chairman JACOBS. We will have the rest of your statement in the record, please.

STATEMENT OF ANN M. MAGENHAN, OFFICE OF DISABILITY OPERATIONS, SOCIAL SECURITY ADMINISTRATION, ON BEHALF OF THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Ms. MAGENHAN. My name is Ann Magenhan, I am currently employed as a benefit authorizer technical assistant in the Office of Disability Operations in Baltimore. My primary task there is to assure the quality of the disability payments.

Mr. Chairman, thank you for inviting me today to testify. I will try not to highlight the entire written report, including the documents, but I ask that this written information be included along with my oral testimony.

Systems modernization, as I am seeing it in the Office of Disability Operations, means removing validations from the systems programming that previously insured program integrity. Verbalized and published comments from the agency's executives of producing more work by fewer people is technically impossible. However, by implementing systems programming that deletes the verification of data, it is easy to say we are producing more work by fewer people.

In fact, the system is just doing more volume but much less accurate work. For the last 2 years, I have seen numerous claims that had major inconsistencies or inaccuracies being completely processed by the so-called new systems. Just a few years ago these claims would have kicked out until the information was correctly input. This is not the case, now.

Many claims with incorrect information are now being totally processed by the computer. Some examples of just general but major mistakes on claims are as follows: the system deleting total records of claims when overlaying information, such as when changing the type of entitlement. An example would be an uninsured to an insured claim.

The system allowing the entitlement of auxiliary on a disability claim without actually having a disabled primary claim entitled. How do we pay children of a disabled parent without having the disabled parent on the rolls? Again, this is a programming decision.

The system processing return checks by dropping off the first digit and repaying the remainder. An example would be a check is returned to SSA by the post office for address reasons. The amount of the check was initially $17,000. When the system repaid it, it dropped the first digit and repaid a check for $7,000 instead of $17,000.

The system processing cases involving civil service and earnings outside the civil service as Federal workman's comp cases. In actuality, there was no workman's comp. However, the offset computations are totally different and yet the check was still paid.

These examples are just to highlight the quality of programming that we see in the office of disability operations. The question I must ask, beyond the incorrect claims I'm seeing as a reviewer is, how many and how inaccurate are the claims I am not seeing? In my opinion, it is a large volume with pretty low accuracy.

The agency's method to managing workloads is to obsolete a good portion of systems programming that verifies information. I realized years ago that quality was not a priority in the agency, but I did not believe that I would actually see deletions of validations to defend the staffing cuts.

I now believe that the next step in this type of management is to have legislation passed that removes all computations that cannot be done by a computer and are not cost effective. The end result will be no backlogs, quicker processing times, and massive reduced staffing.

But more so, Mr. Chairman, we will soon find ourselves with no quality product being delivered to those that support the system by paying into Social Security.

Thank you again, Mr. Chairman, for this opportunity to present this information. I will be happy to answer any questions about the program, if not in person, in the record. And I ask that my testimony from the subcommittee, from July 28, be entered also into the record regarding the quality of SSA claims being adjudicated.

Thank you.

[The statement of Ms. Magenhan follows:]

TESTIMONY BY

ANN M. MAGENHAN

Mr. Chairman, thank you for inviting me to testify today regarding the Disability Operations of the Social Security Administration. As I have previously testified on July 28 before the House Subcommittee on Human Resources and Intergovernmental Relations, I will try not to duplicate that information.

I am pleased to report that after my testimony on July 28, I have noticed some minor changes with regard to the selection of claims for quality review in my area. Any improvements, no matter how minor, are a positive sign to me.

Mr. Chairman, I am not going to highlight the entire report orally, but I ask that this written information be included with my oral testimony.

Again, Mr. Chairman, thank you for this opportunity to present this information. I will be happy to answer any questions about the Disability Operations that you or the Committee members may have, if not in person, then for the record.

A few years ago, a practice among lower level managers in the Office of Disability Operations (ODO) in Baltimore, Maryland, was to go into backlog locations and strip claims folders of material that needed manual processing. Normally, the material was destriyed and the claims folder was then returned to merged files as if the action had been completed. Sometimes the material was recycled, i.e., held until it was statistically feasible to process it. Other similar management practices have been used in the Office of Disability Operations to reduce backlogs and cut processing times from delaying the association of claims material with folders to making false labels for claims folders not available or located.

During the last couple of years, the techniques of managing the workload have been refined. Instead of stripping claims folders of material, inflating receipts or delaying the processing of claims material, current management has chosen other avenues. The following are examples of techniques being used to reduce backlogs, cut processing times and reduce staffing in the Office of Disability Opertions:

- "Writing off" overpayments by citing "not cost effective" to pursue recovery, e.g., DTS #87-136 and DTS #87-157, 6/87;
- Shifting primary workloads from trained personnel to untrained personnel without regard to training needs, quality or integrity issues, e.g., DOPA;
- Implementing policy decisions that are advantageous to the Agency byt are disadvantageous to the claimant, e.g., RN02210.045, i.e., requiring the claimant prove hardship due to the Agency's inaction or untimely processing;
- Due to staffing cutbacks, implementing policy decisions that expand (drastically) the scope of responsibility for policy interpretation to the level of technicians, e.g., DTS #777, 4/87;
- To cut workloads, reprogramming computer systems to eliminate validations which previously had insured program integrity;
- Substituting informal question/answer notes for POMS procedure due to the moratorium, e.g., final RATA counterpart meeting notes (Attachment B);

- Limiting most examiners/authorizers scope of responsibility to the payment identifier code (PIC) specified on source documents and the prior action by the same technical position, e.g., Memorandum of Understanding, revised 8/25/82, item #10;
- Utilizing statistically inaccurate figures to assess quantity and quality of disability workloads.

All of these manuevers are undercutting the quality and integrity of the Social Security system. Systems maodernization has meant faster processing but poorer quality. Claims and post-adjudicative actions that had to be worked manually just a few years ago now are processed completely by the system. However, this doesn't indicate the system has been programmed better when taking a closer look at the processed actions. It doesn't reflect that quality has improved. Eliminations of validations that previously insured the accuracy of the imput information have been programmed into the system. In many instances, the likelihood of correcting the claims will never be realized. In addition, the scope of responsibility of personnell is limiting what corrective actions will be taken.

Training in areas besides systems modernization has been at an all-time low in the Office of Disability Operations. Many training sessions presented are ineffective and, thus, not cost effective. Requested training in areas of inefficiency often go unheeded for years due to budget and staffing cuts. On the job training is scarce because of the loss of productive hours and the enormous time involved. Many technical assistants due to their own lack of training feel unqualified to train peers and subordinates. Pressure to move workloads is a primary task, whereas training is secondary.

Due to the POMS moratorium, POMS procedure has been distributed on a limited basis. In many instances POMS procedure has been temporarily replaced by informal question and answer notes submitted by technical assistants to the Operations Support staff. The end product is often incorrect, not to mention confusing, disorganized, and not nationally circulated or consistent.

In addition, staffing cuts and the ongoing practice of emphasizing production rather than quality has caused management to implement policy decisions drastically expanding the scope of responsibility for policy interpretation to the level of technicians. This implementation creates situations of personnel processing cases without regard for uniformity, legal precedence, rationale behind legal decisions, ect. Any technician can and will process cases based on individual interpretations and judgements. The end result will be similar cases being worked differently because the judgement decision has been delegated to technicians.

The continuing trend seems to be moving towards almost complete automation without any program integrity. More and more personnel are becoming acclimated to producing numbers rather than producing quality work. A level of incompetence is being created due to the loss of experienced, caring personnel who had a high regard fr programs integrity. Personnel who went the extra step are becoming few and far between. Morale is not at an all-time high peak. Action needs to be taken soon to reverse or at least retard the trend.

SSA PROGRAM CIRCULAR

General Series

No 87-136 **OFFICE OF DISABILITY OPERATIONS** Date: JUN 02 1987

SUBJECT: Recovery of Overpayments--Selection of Contingently Liable Beneficiaries in the Same Household

AUDIENCE: BAs, BATAs, RECOVRs, RECOVTAs, RCs and Program Analysts

REFERENCE: POMS GN 02210.005, .006, .015.C1.b., GN 02210.040.D.3, GN 02245.040, .050.D, GN 02280.800, CN 00703.114, .116, GN 01503.001, GN 02280.801 and General Series No. 86-219

POMS GN 02210.005 advises that adjustment of benefits to recover an overpayment under Section 204(a) of the Act is accomplished by withholding the title II benefits payable to:

1. The overpaid individual (or a representative payee who received an overpayment on behalf of a beneficiary); (primarily liable); or
2. Another person who is receiving benefits on the same earnings record on which the overpayment was made (contingently liable).

[redacted]

SSA has agreed to conduct a one-time ROAR/MBR match operation to identify those title II overpayment cases where collection activity was terminated while other beneficiaries in the debtor's household continue to receive benefits under the same account. The match operation will also identify beneficiaries in current pay status, regardless of household, if the BIC on the MBR is equitable to the BIC on ROAR (e.g., BIC B2 on ROAR, BIC B on MBR). These cases are to be reviewed, with corrective action taken where needed.

PUBLISHED BY OPERATIONS SUPPORT STAFF /Payment Group

FOR INFORMATION CONTACT: Your Program Analysts

SSA Pub. No. 54-076

DESTRUCTION DATE: 11/13/87

SSA PROGRAM CIRCULAR

General Series

No. 87-157 **OFFICE OF DISABILITY OPERATIONS** Date: JUN 18 1987

SUBJECT: Improving Delinquent Debt Clearances

AUDIENCE: RECOVTAs, RECOVRs, RCs, BAs, BATAs, EHISs, Program Analysts and RECONRs

REFERENCE: None

[redacted]

These instructions will be incorporated into POMS at a later date. Overpayments under $3,000 will be written off if the following conditions are met:

1. No other beneficiary is in current pay on the same record;
2. No waiver or recon issues are pending;
3. No refunds or repayment agreements have been received in the past 6 months; or
4. Initial overpayment letter has been sent and jurisdiction was transferred to IBFS and returned as uncollectable.

   (No additional development will be undertaken to recover this type overpayment. If development is in progress, advise the DO to discontinue their collection efforts since ODO will be terminating collection activity.)

If the above conditions are met the reviewer should prepare an SSA-1112 TC71 and document the claims file with an SSA-2210.

Overpayments under $3,000 will not be referred to DOJ.

PUBLISHED BY OPERATIONS SUPPORT STAFF/Payment Group

FOR INFORMATION CONTACT: Your Program Analysts

SSA Pub. No. 54-076

DESTRUCTION DATE: Indefinite

cy's potential for collection in the event reconsideration affirms the overpayment.

If the debtor requests waiver of repayment, the request should be developed. To qualify for waiver, the debtor must always be without fault in causing or accepting the overpayment. In addition, the debtor must prove that recovery would "defeat the purpose of the title" or be against equity and good conscience.

B. Control of Overpayment Repayment

After response (or lack of response) to the initial notice of overpayment, overpayments are considered collectable if there was no request for waiver or reconsideration. If the overpayment is to be collected by adjustment, the system will control collection of the overpayment (after any necessary initial triggering of the automatic payment adjustment). If adjustment stops before full collection of the overpayment, a notice requesting full refund of the remaining overpayment should be sent.

Implementation in the six PSC's of the IBFS for title II and title XVI overpayments for which refund is the method of recovery to a great extent replaces the ROAR control of title II and the SSR and DO control of title XVI overpayments which are not recovered by adjustment.

The IBFS generates monthly bills, alerts for telephone followup by the Debtor Contact Section (DCS) and controls for resolution of overpayments of $30 or more. (GN 02210.200 ff.)

When the debtor does not respond to SSA's requests for repayment or responds but is unwilling to repay the overpayment, there are four possible actions which SSA can take:

1. propose repayment of the debt through adjustment against persons who have contingent liability (GN 02205.001 D.),
2. suggest a "compromise" proposal to the liable person (GN 02215.100),
3. refer the case for enforced collection (i.e. civil suit, if appropriate) (GN 02215.150), or
4. discontinue collection of the overpayment (cataloging the overpayment as a "bad debt") (GN 02215.235).

02201.004 Administrative Tolerances on Initiating and Continuing Recovery of Overpayment

AUDIENCE: *BA, BATA, CA, CDA, CR, CRTA, RECOVR, RECONR*

A. General

The effort to collect a debt should generally not cost more than the amount of the debt itself. With this in mind, SSA has set certain administrative tolerances restricting the amount of activity on certain classes of debts.

B. When There Will Be Notice of Overpayment

1. OVERPAYMENT LESS THAN $1.00

a. Title II/Black Lung

For overpayments processed manually, there will be no notice of overpayment if the overpayment is less than $1.00.

When overpayments of less than $1.00 are computer processed, the system may send an overpayment notice and initiate payment adjustment. If a liable person who has received a computer generated overpayment notice of less than $1.00 requests waiver of recovery of the overpayment, grant the waiver automatically (without development) on the basis that recovery of such a small amount would impede efficient or effective administration of the Social Security Act. However, if there is no objection to the collection, SSA will recover these small amounts from the monthly benefit and will accept refund.

b. Title XVI

When a title XVI overpayment is less than $1.00, there will be no notice of overpayment. Effective with the implementation of AONS, the system will automatically apply an uncollectible decision. (SM T01310.060 B.)

If the overpayment is reduced to less than $1.00 after the initial overpayment notice is sent, the system automatically applies the uncollectible decision (see SM T01310.150 B.2.).

2. OVERPAYMENT IS $1.00 OR MORE BUT LESS THAN $30.00

a. Title II/Black Lung

When an overpayment is $1.00 or more but less than $30.00, an overpayment notice will generally be sent when:

1) the notice is automated, or
2) adjustment can be proposed against the debtor (i.e., the person is in current payment status within the same program); a lump-sum death payment is payable (GN 02205.001 B.); or there are other beneficiaries currently eligible for payment on the same earnings record against whom adjustment can be proposed (GN 02210.015), or
3) a manual notice is being prepared for a reason other than to request repayment of the overpayment (e.g., a change in the monthly benefit of a person in suspense status).

When the above criteria are not met, there will be no notice of overpayment.

NOTE: *If an overpayment notice is not sent, a ROAR record should not be established.*

b. Title XVI

1) When a title XVI overpayment is $1.00 or more but less than $10.00 and the debtor is in current payment status and the automated overpayment notice cannot be sent, the overpayment will be administratively declared uncollectible. When an overpayment is more than $10.00 but less than $30.00, and the debtor is in current payment status, a manual notice must be sent. The overpayment will *not* be declared uncollectible.
2 When a title XVI overpayment is $1.00 or more but less than $30.00 and the debtor is

A beneficiary will be considered to have caused or helped to cause an overpayment where the overpayment was caused in whole or in part by his misstatement of pertinent facts or withholding of material information from SSA.

Example:

Although they were not in the same household, Betty Clay was awarded wife's benefits on the basis of statements regarding her marriage made by her on an SSA-2-F6 (Application for Wife's Insurance Benefits) and corroborating statement by the NH, Norm Clay, when he completed an SSA-1-F6 (Application for Retirement Insurance Benefits) and SSA-3 (Husband's Certification). Later, it was determined that the parties were not married and that the payment of wife's benefits was incorrect. Since Norm knew there was no marriage, the overpayment was caused by his misstatement of pertinent facts. Propose recovery of the overpayment of wife's benefits from benefits payable to Norm if Betty fails to refund the incorrect payments in 30 days.

Also, see section GN 02201.050.

02210.040 Considering Different Rate of Adjustment

AUDIENCE: *BA, BATA, CA, CDA, CR, CRTA, IES, RECONR, RECOVR*

A. General

When a person currently eligible for payment of title II or Black Lung benefits is liable for repayment of an overpayment under that program, the initial notice of overpayment will request refund of the overpayment and propose withholding the full benefit if full refund is not received within 30 days of the notice of overpayment. The notice also advises the person to let us know if the planned full withholding will cause financial hardship.

B. Partial Withholding Not Permitted in Fraud Situations

Regardless of a person's financial circumstances, partial withholding to recover an overpayment which was the result of fraud (i.e., an intentional false statement or representation by the person against whose benefits adjustment is being made, or by his willful concealment or a deliberate failure to furnish material information - GN 04105.020) is never allowed. This bar to partial withholding operates only when the Department of Justice (DOJ) or the Office of Inspector General (OIG) determines that fraud exists. When an overpayment is being recovered by partial withholding and DOJ or OIG subsequently determines that the overpayment was caused by fraud (whether or not prosecution is recommended), the partial withholding should be changed to full withholding (except for SMI premiums) to recover the balance of the overpayment. Make certain that the beneficiary receives notice of the change in the withholding prior to the payment delivery date for the next check.

C. When to Consider Different Rate of Adjustment

1. WAIVER REQUEST NOT INVOLVED

Consider a different adjustment rate when the person specifically requests a different withholding from what has been proposed (or is in effect) or otherwise indicates that the planned full (or actual) withholding is causing financial hardship.

When full withholding has been proposed (or the benefit is being withheld in full or in part) to recover an overpayment and the person does not take issue with the overpayment or the need for recovery but clearly seeks only a different withholding, see GN 02210.045.

2. WAIVER REQUEST INVOLVED

a. At Fault

If a person is at fault in causing the overpayment, initiate full withholding when waiver is denied (i.e., a personal conference is not pending) unless:

1) A specific request for partial withholding was received in connection with the waiver request (e.g., a person requests a monthly withholding of $40 if we do not waive recovery); or
2) The person is also receiving title XVI benefits. If so, only withhold 10 percent of the title II monthly benefit.

If neither of the above situation exist and waiver is denied on the basis of fault, full withholding is in order, and a lesser withholding will be considered subsequently only if (a) a specific request for partial withholding is received after the waiver denial notice is sent or (b) the waiver denial is appealed.

b. Without Fault

If a person is without fault in causing the overpayment but waiver is denied because recovery would not cause hardship, full withholding may be inconsistent with the defeat the purpose finding. Withholding in such case cannot be greater than what the defeat the purpose finding allows, regardless of the length of time that recovery would take (or that recovery would not be completed before entitlement will terminate). If, for example, a person is without fault in causing a $4,500 overpayment but waiver is denied because the person can afford to repay $65 a month (after the $25 adjusted expense margin - GN 02250.170) without financial hardship, adjustment is limited to the $65.

02210.045 Establishing Different Rate of Adjustment

AUDIENCE: *BA, BATA, CA, CR, CRTA, IES, RECONR, RECOVR*

A. DO Procedures

When a person requests a different rate of withholding, do not have the person complete an SSA-561-U2. If the requested lesser rate of repayment would permit full recovery within a 36-month period or before termination of entitlement, whichever is sooner, and is at least $10 a month, do not develop financial information. However, if recovery at the rate requested would not be completed within 36 months (or before entitlement will terminate) or would be less than $10 monthly, have the person complete parts III and IV of the SSA-632-F4 and obtain necessary verification per GN 02245.050 D. If the person is receiving cash public assistance (GN 02250.160), have the person complete only part III of the SSA-632-F4 and verify public assistance in accordance with GN 02245.040 and GN 02245.050 C.

Prepare and input an SSA-3079 (i.e., using Type of Action Code "B") if there is a ROAR record of the overpayment (SM 00610.001). Based on the SSA-3079 input, full benefits will be issued until the PC processes the request for the lesser rate of adjustment. Annotate the request (e.g., SSA-795) "ROAR Input (Date)." If adjustment has been proposed and no ROAR record exists, use form SSA-2521 (GN 02240.005) to transmit the request to the PC; transmit any necessary development which is delayed when received.

B. PC Procedure

If a lower withholding is requested, process as follows:

1. DETERMINING THE WITHHOLDING AMOUNT

Grant the request for lower withholding unless:

a. There is current financial information available (e.g., an SSA-632-F4 has been submitted); or

b. The requested withholding amount would not permit recovery within 36 months or prior to termination of entitlement; or

c. A withholding of less than $10 is requested.

In any of the above situations, refer the case to the recovery reviewer after preparing an SSA-1112, TC-23, request code "B."

If a request for waiver of recovery *is* involved, the recovery reviewer will follow GN 02210.040 C.2. to determine the rate of recovery. If a waiver request is *not* involved, the recovery reviewer will evaluate income, resource and expense information on the SSA-632-F4. Withhold:

1) The amount by which the person's income exceeds expenses (GN 02250.170); or

2) If excess resources (GN 02250.190), at the rate (up to 100 percent exclusive of SMI premiums) permitted by the income/resources; or

3) The full monthly benefit (after deduction for any SMI premiums) to the extent of any incorrect funds in the person's possession (GN 02250.155).

If the person is receiving cash public assistance (GN 02250.160), withhold at the rate requested as long as the person does not have any of the incorrect funds in his/her possession.

Also, if a person requests a greater rate of withholding than would be established under the above rules or the GN 02210.040 C.2. guidelines, withhold at the rate requested.

2. EFFECTIVE DATE OF LOWER WITHHOLDING RATE

If a request for a different rate of adjustment is made prior to effectuation of withholding, the requested withholding, if approved, will be effective with the first month for which full withholding was proposed. If development is required (see A. above), postpone adjustment until a decision can be made as to the withholding amount.

A request for a different withholding made after adjustment (full or partial) has been initiated will apply only to current (i.e., current operating month) and future benefits [illegible] evidence [illegible] the person suffered a hardship between the time the request was made and the time it was effectuated [illegible] money, defer payment of bills due). If hardship can be shown, a lesser withholding will be effective with the first month for which hardship is established.

3. INITIATING THE RATE OF ADJUSTMENT

Initiate via either ROAR or MADCAP as outlined below.

a. To begin adjustment against the overpaid beneficiary, prepare a SSA-1112, TC-41 (SM 00610.075). ROAR will start the benefit adjustment with the month reflected on the SSA-1112 and will produce an SSA-3926-C2. Where a different amount of withholding is established than was suggested by the beneficiary, send a manual notice (GN 02210.060) informing him of the amount. Prepare a MADCAP or ROAR action to change the withholding rate.

b. When the first ROAR diary matures to begin adjustment against someone other than the overpaid beneficiary, proceed as follows:

1) If the original amount of overpayment has been reduced, prepare an SSA-2795-U3 to remove the overpaid beneficiary's OPA from the MBR. Prepare another SSA-2795-U3 to establish the overpayment against the other beneficiary, implementing full withholding of benefits to recover the overpayment. At the same time, notify the other beneficiary of proposed adjustment of the overpayment.

2) If the original amount of overpayment has not been changed, prepare an SSA-1153, TC-07 to remove the overpaid beneficiary's OPA from the MBR, and prepare an SSA-1112, TC-10 to establish the overpayment against the other beneficiary. At the same time, notify the beneficiary of the proposed adjustment of the overpayment.

NOTE: *If the other beneficiary's benefits are terminated, suspended, or recovery from the other beneficiary is waived, take action to reestablish the overpayment for the originally overpaid beneficiary.*

02210.060 Giving Notice of Adjustment Decision

AUDIENCE: *BA, BATA, CA, CR, CRTA, IES, RECONR, RECOVR*

A. Different Rate of Adjustment Established

If a different rate of adjustment is approved, the PC will send written notice indicating the new payment amount, the amount to be withheld each month, the effective date of withholding, the overpayment to be recovered, and when recovery at the rate established will be completed.

B. Request for Lesser Rate of Adjustment Denied

If a request for lesser withholding is denied in whole or in part, the PC will send written notice, stating the basis for it and the manner in which the overpayment will be recovered.

ADVANCE COPY

DISABILITY SUPPLEMENT
OFFICE OF DISABILITY OPERATIONS

SUBJECT: Program Operations Manual System (POMS), Part 02, Chapter 010, Subchapter 10, Adjudicative Policy and Standards

New Material	No. of Pages	Replaces	No. of Pages
GN D01010.007	1	GN D01010.010	1
GN D01010.030	1	GN D01010.031	1
GN D01010.800	9	GN D01010.800	1

TOPIC OF MANUAL CHANGES

[redacted] the Assistant Regional [redacted] prepared [redacted] include a factsheet.

-ACTION-

Cross-refer DI 40001.035 to GN D01010.800.
Obsolete entire Disability Supplement No. 552.

Disability Transmittal No. 777

The last prior supplement to this manual was DTS #770

Published by OSS, Technical Group

Distribution: BAs, BATAs, CAs, CATAs, DEs, DECs, DSs, EHISs, ERs, RECONRs, RECOVRs, RCOVTAs, RECONEs and Program Analysts

For Information, Contact: Your Program Analyst

Effective Date: Upon Receipt

DISABILITY SUPPLEMENT - ODO

DTS #777
Date: 01/87

POMS, Pub. No. 68-0201010

GN D01010.007 Adjudicative Responsibilities

A. Signature of Adjudicator

Each folder released by a technician should contain some form of documentation reflecting the action taken or an entry certifying that no action was necessary. If no action was necessary, the adjudicator should annotate the folder either by inserting an SSA-0924 folder documentation or by entering "NAN" (with an accompanying explanation, if appropriate) on the top piece of material on the right-hand side of the folder. This documentation should be followed by a legible signature (first initial and full surname), module or branch number and the date. As indicated in GN 00301.050, be careful not to mark, underline, annotate or otherwise deface documents of evidentiary value, such as written statements from claimants or witnesses, reports of contact, medical evidence, etc.

B. Folder Documentation

Whenever action is taken which differs from manualized procedure, the folder should be properly documented by an SSA-0924. This is especially true in judgemental issues and actions taken in accordance with internal operating instructions.

Any claim that has more than one acceptable way of processing should be resolved at the branch level. Do not submit these judgemental issues to OSS for resolution. The TAs or consultants in each branch should confer on any judgemental issue. They should come to a consensus, document the folder with an SSA-0924 and return it to the technician for processing.

Technicians will include a computation printout (where applicable) or a worksheet (SSA-553, SSA-0924 or other POMS worksheet) in each case involving a reduced benefit, dual entitlement, combined family maximum or workers' compensation lump sum proration. The computation documentation must be left in the folder whenever the programmable calculator or SSADARS computational program is used to compute a benefit amount.

DISABILITY SUPPLEMENT - ODO

DTS #777
Date: 01/87

POMS, Pub. No. 68-0201010

GN D01010.030 Verification of Prior Period of Disability

All prior periods of disability shown on the SSA-794 should be preadjudicatively verified by a master beneficiary record (MBR) unless otherwise verified by microfiche or the prior folder. However, do not request an MBR if the dates to be verified are prior to January 1962, because MBR data is only available beginning with January 1962. If the prior folder is not available (at present, terminated folders are destroyed after 10 years retention in the Federal Records Center), accept the Office of Central Records Operations record on the SSA-794.

DISABILITY SUPPLEMENT - ODO

DTS #777
Date: 01/87

POMS, Pub. No. 68-0201010

GN 01010.800 Resolving Policy and Legal Issues

A. General

Most of the policy and legal issues that arise in the adjudicative process can be resolved by reference to POMS or to precedents and Social Security rulings in the Reference Room (2-F-11 DT). Occasionally, it will be necessary to submit unresolved cases to the appropriate policy staff in central office or to the regional chief counsel (formerly attorney). The guidelines which follow explain how such cases should be prepared and routed. If you cannot determine whether or not a particular case should be submitted, your TA/consultant should contact OSS through your division program analyst for advice. Any case referred to the division analyst for guidance should have a completed factsheet (exhibit 1) attached.

B. Legal Questions Involving State Law (GN 01010.830)

Questions involving State law and questions of whether or not a State recognizes a foreign marriage, adoption, divorce, etc., are resolved by the regional chief counsel. The POMS procedures on evidence of relationship found in GN 00300.ff usually specify when to submit questionnable cases to the regional chief counsel. For example, GN 00305.050 requires submittal if there is a question as to whether a marriage is void or is merely voidable, and GN 00306.055 requires submittal if a question arises concerning the sufficiency of evidence needed to rebut the presumption that a child born in wedlock is the natural legitimate child of the mother's husband. These kinds of State law questions cannot be resolved by central office policy components, but only by the regional chief counsel.

As noted in GN 01010.830, cases needing a regional chief counsel opinion must be submitted from the Director, ODO to the Assistant Regional Commissioner (ARC), Programs, for the region which includes the State of the number holder's domicile (see GN 00305.010 regarding domicile). All submittals to the ARC will be made through OSS, 7070 DT, but the module or reconsideration staff making the referral will prepare the necessary memorandum (see exhibits 2 and 3). The memorandum must be typed and must clearly state what issue needs resolution and the facts at issue (include relevant POMS citations). The TA/consultant's name and FTS number should be placed in the closing paragraph of the memorandum. A factsheet must be submitted to OSS along with the memorandum (exhibit 1). Give the chronological sequence of the facts, the issue in question, and all procedure references utilized from POMS and/or the

DISABILITY SUPPLEMENT - ODO

DTS #777
Date: 01/87

POMS, Pub. No. 68-0201010

GN D01010.800 (cont'd)

Submittals should be routed to OSS after clearance by the modul manager/reconsideration staff manager, branch manager and division office. Any folders received in OSS without the prope routing or factsheet will be returned unanswered to the division.

C. Requests for Interpretation of Policy (GN 01010.855B. and GN 01010.860B.)

All non-State law policy issues will be submitted to the Office of Retirement and Survivors Insurance (ORSI), the Office of Disability (OD) or, rarely, the Medicare Bureau in the Health Care Financing Administration (HCFA), depending upon the issue at hand. Generally, RSI issues concern POMS Parts 2, 3 and 9, disability issues concern POMS Part 4 and Medicare issues concern POMS Part 6. All submittals to ORSI, OD and HCFA must be typed, must receive clearance as in B. above and must go through OSS. (See exhibits 4, 5 and 6 for examples of a submittal to OD.) Remember to check the Reference Room before preparing a submittal.

D. [redacted]

There will be instances where a submittal for policy/procedure interpretation or clarification is appropriate. That is, the POMS does not provide the general policy/procedure or there is conflicting procedure. In these situations, the issue and the folder should be submitted in accordance with the guidelines in this supplement. See exhibits 1, 4, 5 and 6 and item C [illegible]

GN D01010.800 (cont'd)

E. Exhibits

Exhibit 1--FACTSHEET (must be included with all folders submitted to OSS and to the division program analyst)

Exhibit 2 and 3--Examples of memoranda to the ARC (State law policy issues)

Exhibit 4 and 5--Examples of memoranda to OD (non-State law policy issues)

Exhibit 6--Example of memorandum to OD (State law policy issues)

EXHIBIT 1

FACTSHEET

Wage Earner's Name and SSN:

Issue in Question:

Chronological Sequence of Facts:

POMS Reference Relevant to Issue:

References Researched in Reference Room:

Conclusion and/or Proposed Solution:

Prepared By:
Module:
Date:

ATTACHMENT B

FINAL BATA COUNTERPART MEETING NOTES

Question #1 What is the appropriate method to control overpayment recovery in the following situation. Overpayment amount requires deferral beyond 1999? Currently MADCAP will not accept this situation.

Answer: Any deferral that exceeds past 11/99 must be handled as follows:

-Defer the beneficiary through 11/99

-Prepare an SSA-5015 with a 3 year due diary date from the date the action is taken. Upon the maturity of the diary the overpayment must be adjusted to take into account any increase in benefits. The case should then be redeferred through 11/99 or for the balance of the overpayment.

-Prepare an SSA-5015 listing code 909. If at anytime the overpayment should be recovered before 11/99 or benefits terminate then this listing must be cancelled.

-Prepare an SSA-1208 folder flag. The flag must show the total overpayment and any adjustments made to the overpayment including the balance of the overpayment at the time of adjustment.

Question #2 Please see the attached SSA-1240 and SSA-559 dated 2/22/86. Per instructions from CCE the BA just adjusted Trust Funds. Also, please see the attached Bulletin from Division III PA. How can we tell if the check should be refunded? The check was never returned but we just received a congressional inquiry and this 4/3/86 check should have been refunded. Could procedure be written clearer on these SSA-1240's.

Answer: See GS 87-82 dated 4/9/87 (copy attached).

Question #3 The CN00721.300 transmittal prior to the TN #23 consolidation had a note after the A46 paragraph which said it could only be used with the A18 notice and reason "C". This note is not in TN #23. Does the note still apply. Can paragraphs such as the J23, W45, W46 and W47 be used in ENBs and on 573s even if W/C or work don't apply? Why is it that BAs must give such detailed and often very lengthly explanations of rate changes in their letters? Rate increases which are fully processed by object programs are short and to the point. For example, a fully processed

REVISED
8/25/82

MEMORANDUM OF UNDERSTANDING

QUALITY EVALUATION PROCESS

General

1. The proposed quality evaluation process shall, for the Claims Authorizer, Benefit Authorizer, Recovery Reviewer and Disability Examiner positions, replace the spot-check procedure as referenced in the Memorandum of Understanding "Spot Checks in the Office of Disability Operations", dated July 21, 1981, as the statistical method of evaluating employee accuracy. This may include all data collected under this process, including data gathered under any percentage of review.

2. This agreement and an appropriate list of deficiencies (attached) will be provided to each technician involved.

3. Deficiencies involving judgmental or discretionary issues will be for informational purposes only.

4. Deficiencies noted by the reviewer shall be returned to the employee within 5 working days of pickup. In the event this is not accomplished, the deficiency shall be treated as informational.

5. For 10 working days after the ninth and twelfth month of implementation of this review process, any unforseen effects resulting from this process which have been demonstrated to have an adverse impact on the individual will be cause for reopening specific relevant provisions of this agreement. The review process as proposed will continue pending the outcome of any additional impact bargaining. This provision does not commit management to negotiations on accuracy standards.

B. First Tier Review

1. The First Tier review will be conducted in the modules by technical assistants (T/A's) and disability consultants (normally the TA or consultant assigned to the module).

2. Reviewers will be provided, on a routine sampling basis, a percentage of all cases completed by individuals in the module. Normally, each individual is expected to have 138 of his/her cases reviewed per year. This number could vary depending upon circumstances.

   In those situations in which an individual has limited time on the job due to approved absences during the rating period and the expected number of sample review cases cannot be obtained, the manager will use other findings and observations to supplement the statistical data in assessing the individual's performance level.

3:

3. The Records Maintenance Clerks (RMC's) will be provided proper training prior to performing the sample selection assignment.

4. To the extent possible, amounts of time will be adequately alloted to RMC's to complete the sample selection assignment to assure that performance standards and individual evaluations are not adversely affected.

5. To the extent possible, the sample selection assignment will be rotated equitably among qualified RMC's.

6. To the extent possible, First Tier review activity will be equitably shared by TA's and consultants within the module.

7. Actual performance interviews recorded for an employee's SF-7B file shall not be function of the reviewers. Direct appraisal of performance and final determination of performance levels in application of performance standards will remain an area of management responsibility.

8. Cases showing deficiencies used for performance evaluations shall be returned to the individual reviewed with a notation describing the deficiency in relation to the deficiency lists and proper references.

9. Individual may rebut a deficiency orally and/or in writing to the first line supervisor. When necessary, because of ill-defined issues, the supervisors should seek the technical advice of the division's Operations Specialists in clarifying the error. Rebuttal of deficiencies shall not be a cause for adverse implication or retribution against employees.

10. Technicians will be responsible for their current action and the most recent action pertaining to the same PIC by the same technical position. This responsibility will pertain to Claims Authorizers, Benefit Authorizers and Recovery Reviewers. Disability Examiners will be responsible for their current action and, if the current issue involves TWP months and/or SGA decisions, the examiner will review and consider prior work information in the file as it relates to the current action.

11. The numbers of cases reviewed for each individual shall generally be consistent with Item B,2. Managers may, at their discretion, review fewer cases for an individual when superior performance is demonstrated or progressively increase the number of cases reviewed for an individual when necessary to support findings and observations of less than fully satisfactory performance. Should a manager find it necessary to substantially increase review, the individual will be given proper advance notification by the manager.

12. Supervisors will to the extent reasonable, consider special circumstances which create a misleading adverse impression of the individual's performance based on data alone. Substantial increase in review and abnormal overtime work data are examples of what may be considered special circumstances. Supervisors may appropriately document employee 7B files to reflect an accurate picture of the employee's productive efforts in such instances. Such documented situations shall receive due consideration in evaluation of employee performance for appraisal purposes.

13. Errors for actions on which an individual has not been trained will be considered informational only.

14. Overtime work will be treated in accordance with Article 10 Section I of the General Agreement between parties which was effective September 15, 1977, to the extent that such article remains effective under the provisions of the National Agreement between the parties effective June 11, 1982. If the Article is found to be no longer in effect, within 15 work days of such final determination, the union may request a reopening of impact bargaining on this issue in accordance with Article 4 of the National Agreement.

15. Prior to taking any adverse personnel action on an employee on the basis of accuracy arrived at by this method of quality evaluation, 5 months statistical data should be accumulated from the effective date of implementation of this review except that in cases of individual abuse where the Agency work processing is seriously affected by lack of individual accuracy, action may be taken after a reasonable amount of data is compiled and other observation indicates below standard work performance. This provision does not apply to actions involving less than fully satisfactory performance already in progress at the time this review is implemented.

C. Second Tier Review

1. The Second Tier review will be conducted at the ODO level for the purpose of ensuring the effectiveness, validity and uniformity of the First Tier review process. This review will not assess the individual performance of T/A's, consultants or other technicians.

2. Details to the Second Tier review group will be for a period not to exceed 120 days and will, to the extent possible, be equally representative of each module division. Detailees will, to the extent possible, be selected from a list of qualified volunteers on a rotational basis.

3. No existing or future contract right or Memorandum of Understanding will be abridged as a result of the terms and conditions of this agreement.

4. The parties agree that disputes regarding the implementation and application of this document may be resolved by referral to appropriate authorities under Title VII of the Civil Service Reform Act.

5. This memorandum of understanding shall be come effective on the date it is signed by the parties.

FOR THE ADMINISTRATION

8/25/82
Chief Negotiator DATE

Carl J Clayton 8/25/82
Negotiator DATE

8/25/8
Negotiator DATE

FOR THE UNION

John Gage 8/25/8
Chief Negotiator DATE

Elmer Flannery 8/25/
Negotiator DATE

Negotiator

Chairman JACOBS. I think we can probably swing that.

Mr. Archer will inquire.

Mr. ARCHER. Mr. Chairman, I have no questions, but I appreciate the testimony of the witnesses.

Chairman JACOBS. I think that will do it.

Thank you very much for your contribution.

Mr. Archer, in essence, the cochairman of the panel, has a statement which he will make for the record at this time.

Mr. ARCHER. Mr. Chairman, I appreciate your scheduling this hearing this morning and focusing on the State agencies which make the disability determinations for the Social Security Administration. Particularly in view of the workload effect of the Disability Benefits Reform Act of 1984, it is important that we assure ourselves that these agencies have the resources to carry out their important responsibilities.

At the same time, SSA administrators have an absolute duty to monitor the cost per case, the variations in costs between States, and the steady growth of these costs in recent years.

I want to assure Commissioner Hardy that I share her concern with productivity. The demographics of the work place are troublesome. The ratio of workers to retirees continues to decline, from 5 workers per retiree in 1960 to less than 2 to 1 projected for the year 2040.

Mr. Chairman, I have always believed that we should not just take a short term look at Social Security, but one that does extend out and try to anticipate problems in the future. This change in ratio of workers to retirees impacts not only the trust funds, but also the ability of both SSA and the State agencies to recruit and replace employees despite growing work loads. It will be necessary to adopt more efficient ways of doing business in the 21st century.

Let me share a related projection, which I found all the more shocking when I learned that it does not take the AIDS epidemic into account. This relates to the incidence of disability. Usually that is expressed as, for example, 4.5 males per thousand insured workers in a year. The figure for females is about 2.5 per thousand.

However, in December 1986, SSA actuaries released a paper titled "A Death and Disability Life Table for the 1966 Birth Cohort." Cohort, as we know, means a group of individuals having a statistical factor, such as age, in common.

Now for the shocker. The probability that an insured male worker, who attained the age 20 in 1986, will meet the definition of disability before age 67—and that will be the normal retirement age of the future—is 32.2 percent. In other words this study shows a projection that almost one-third of the males, age 20 in 1986, will meet the definition of disability before they reach retirement age.

That represents a staggering number of disability claims, especially when we add to that 32 percent, those who will file and be denied or those who file for SSI benefits. Interestingly enough, the study shows that the probability for women workers is significantly lower, about 24 percent.

In my view, the demographics of the work place and the cumulative incidence of disability will impact heavily on State agency workloads and operating methods. It seems likely the program will continue to be the focus of congressional oversight and further legislation.

I thank the witnesses who have taken this opportunity to testify today. Referring to the subcommittee press release of September 17, I am particularly interested in their views on productivity standards and Federal-State relations.

As you know, Mr. Chairman, I have introduced H.R. 2117, the Social Security Procedural Improvements Act of 1987. One of the provisions would permit the Secretary of Health and Human Services to federalize the State agency operations to assure the effective, equitable and uniform administration of the program.

I would be pleased to hear today from witnesses as to their views on that proposal.

I thank you again, Mr. Chairman, for holding this hearing.

Chairman JACOBS. Thank you, Congressman Archer.

The next panel consists of the National Association of Disability Examiners, David Tschetter, president; Lamona Lucas, secretary treasurer. And I believe Jean Merritt from Indiana will not be here today, but Mr. Hancock is here, deputy director, Indiana Disability Determination Division.

You know the rules of the New York State Athletic Commission, that is the 5-minute rule. Please proceed.

STATEMENT OF DAVID TSCHETTER, PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

Mr. TSCHETTER. Thank you, Mr. Chairman. Along with my duties as president of the National Association of Disability Examiners, I am also an employee of the South Dakota Disability Determination Services. I have worked there for 13 years and my current duties include supervising six disability examiners and also serving as one of South Dakota's disability hearings officers.

The National Association of Disability Examiners, NADE, is a professional association that supports the growth, development and advancement of the science of disability evaluation. The major portion of our 2,500 members are examiners, hearing officers, administrators and support staff that are involved in the adjudication of disability claims.

NADE has played an active role in supporting reforms that ensure fair, equitable and compassionate treatment of disabled Americans.

Reforms contained in Public Law 98–460 were viewed as essential by Congress for consistent and compassionate treatment for disabled Americans. Many of the provisions were felt to be time consuming to the adjudicative process, but it was impossible to predict how much time consumption would take place.

It is generally accepted that case loads of 80 to 90 disability claims is manageable by a disability examiner. When case loads rise above this number, it becomes increasingly difficult to process claims in an accurate and timely manner. The most recent statistic on pending work loads per examiner through the country is 123.5 cases.

Recently, NADE had an opportunity to conduct a survey of disability examiners in other related fields. Of this survey, approximately one-half of our membership indicated that their case loads have increased significantly over the past 6 months and also over the past 12 months.

In addition to this increase in caseloads, the amount of documentation required has also increased and has become more difficult and more complex.

Because of the demands for increased productivity by the Social Security Administration, many State agencies have shifted professionals such as disability hearing officers, medical relations officers, quality assurance reviewers and others to full or part time case work. This organizational engineering has resulted in a productivity gain.

However, we believe that these gains that have been realized in this way are short term and that they will vanish as the pressures of primary duties impact on the temporary examiners.

Our survey indicated that there is an increase in demands of disability examiners for productivity. This is felt by many to have an adverse affect on the quality of their work. There has been a significant decline in national accuracy rate for fiscal 1987.

Current productivity expectations are not grounded in fact simply because there has not been enough experience with the more labor intensive processing of disability claims required by Public Law 98–460. One of the distressing facts about the current do-more-with-less philosophy of management is the underlying assumption that decreases of productivity is because adjudicators are not working hard enough.

Current SSA standards of measuring productivity is not a valid or reliable measure of State agency production because it assumes that every DDS is exactly the same. This is not the case. DDS' differ in number of hours worked per week, services contracted out, and the amount of services provided by parent agencies.

While some current initiatives have been developed to correct this, the PDWY still remains less than accurate in measuring DDS performance. A DDS performance measurement should include the agency's cost-per-case factor, processing time, and quality. The latter two are essential to the disabled population that we serve.

When State agency quality, processing time, and cost-per-case factor are low, this must be taken into consideration, along with productions per work year.

I would also like to just add in my testimony, that the adjudication of Social Security disability claims is an extremely complex task. Examiners are routinely required to deal with interplay of abstract medical, legal, and vocational concepts. It takes a year before a new disability examiner is able to become minimally productive.

We are concerned that short term monetary gains resulting from the staffing freeze, because of lack of experienced examiners, in the long run will result in an inability to provide accurate and timely decisions to the disabled population that we all serve.

[The statement of Mr. Tschetter follows:]

ORAL STATEMENT OF

DAVID TSCHETTER

PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

Along with my duties as President of the National Association of Disability Examiners (NADE), I am also an employee of the South Dakota Disability Determination Services, where I have been employed for 13 years. My current duties include supervising six Disability Examiners and also serving as one of South Dakota's Disability Hearings Officers.

The National Association of Disability Examiners is a professional association that supports the growth, development and advancement of the science of disability evaluation. Although there are a number of physicians, attorneys, and rehabilitation professionals who belong to NADE, the major portion of our 2500 members are examiners, hearings officers, administrators and support staff that are involved in the adjudication of disability claims under the programs administered by the Social Security Administration. Over the years, NADE had played an active role in supporting reforms that ensure fair, equitable and compassionate treatment of disabled Americans. Through the expertise that resides in its membership, NADE has been able to provide constructive and effective suggestions to improve the adjudicative process. NADE would like to express appreciation for the opportunity to present testimony on the issue of the condition of State Disability Determination Services.

1. Have the severe restrictions placed by SSA on State Agency funding and staffing levels jeopardized the ability of the State Agencies to implement the provisions of the Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460)?

The reforms contained in P.L. 98-460 were viewed by Congress as essential to ensuring fair, consistent and compassionate treatment for disabled individuals; for restoring public confidence in the Social Security Disability Programs; and for restoring order in the administration of the Disability Programs. It was quite clear that the legislation, which contained 18 provisions, would make the adjudicative process more time consuming. Lacking experience with the extensive changes provided by the new legislation, it was impossible to predict accurately how much more work would be required to process disability claims.

It is generally accepted that a caseload of 80 to 90 Disability Claims is "manageable". When caseloads rise above this number, it becomes increasingly difficult to process claims in an accurate and timely manner.

In March, 1986, SSA imposed a temporary hiring freeze on all State DDS's. According to the SSA, National State Agency Operation Report for the month of August, 1987, the pending workload for a full time examiner is 123.5.

NADE conducted a survey of Disability Examiners and related fields in August of 1987. We believe that the responses to the following questions are an indication of the impact of the implementation of P.L. 98-460, as well as the impact of funding and staffing restrictions.

> Compared to six months ago has your caseload gotten: A) significantly larger B) larger C) no change D) smaller E) significantly smaller F) N/A
>
> A)16%, B)32%, C)23%, D)12%, E)3%, F)14%

Compared to twelve months ago has your caseload gotten:
A) significantly larger B) larger C) no change D) smaller
E) significantly smaller F) N/A
A)15%, B)29%, C)17%, D)18%, E)7%, F)16%

Compared to twelve months ago have documentation requirements on body systems of all types gotten: A) significantly more complex B) more complex C) no change D) less complex
E) significantly less complex F) N/A
A)24%, B)44%, C)24%, D)2%, E)1%, F)5%

Compared to twelve months ago has the time it takes to process a claim from intake to final determination gotten:
A) significantly longer B) longer C) no change D) shorter
E) significantly shorter F) N/A
A)24%, B)42%, C)18%, D)7%, E)6%, F)4%

Compared to twelve months ago has your ability to produce a decision with as much quality as possible been: A) seriously and adversely affected B) adversely affected C) no change
D) improved E) materially improved F) N/A
A)11%, B)37%, C)38%, D)6%, E)1%, F)7%

The DDS' have experienced significant budget cuts. How has this affected you: A) increased caseload B) increased pressure to determine more cases C) decreased ability to do quality work D) threats of or actual reductions in staff
E) all of the above F) no effect
A)11%, B)14%, C)14%, D)11%, E)38%, F)12%

2. How have the State Agencies responded to these budgetary constraints and has this led to any deterioration in the quality and thoroughness of disability case development, documentation and reviews?

Because of the demands for increased productivity by the Social Security Administration, many State Agencies have shifted professionals such as Disability Hearings Officers, Medical Relations Officers, Quality Assurance Reviewers and others, to full or part-time casework. This "organizational engineering" has resulted in productivity gains. However, we believe that the productivity gains that have been realized in this way are short term gains that will vanish as the pressures of primary duties impact on the "temporary" examiners.

Our survey indicated that there are increased demands on Disability Examiners for productivity. This is felt by many to have an adverse effect on the quality of their work. There has been a significant decline in the national accuracy rate for fiscal year 1987.

3. Are SSA's productivity guidelines realistic and is the method SSA utilizes to measure productivity accurate, consistent or nationally uniform? If not, how could these productivity standards be improved?

There has been a steady decline in productivity in the Disability Program for several years. Until recently, productivity was not central to SSA management of the DDS. Current productivity expectations are not grounded in fact simply because there has not been enough experience with the more labor intensive processing of disability claims required by P.L. 98-460. One of the distressing facts about the current "do more with less" philosophy of management is the underlying assumption that the decrease of productivity is because adjudicators are not working hard enough.

The current SSA standard of measuring productivity, "Production Per Work Year" (PPWY), is not a valid or reliable measure of State agency production because it assumes that every DDS is exactly the same. This is not the case. DDS's differ in number of hours worked per week, services contracted out, and amount of services provided by parent agencies. While some current initiatives have been developed to correct this, the PPWY still remains less than accurate in measuring DDS performance. A DDS's performance measurement should include the agency's cost per case factor, processing time and quality. The latter two are essential to the disabled population that we serve. If a State agency's quality, processing time and cost per case factor are low, this must be taken into consideration along with the PPWY.

4. Does a climate of crisis and disruption continue to plague the day-to-day administration of the disability program, and, if so, how can order and stability, the key objective of the 1984 legislation, be restored to the administrative process?

We do not feel that the current situation is comparable to that which existed prior to the passage of the disability reform legislation. However, it does not appear that DDS Administrators have the necessary day-to-day flexibility that they must have in order to manage State agency workloads. Moreover, there is an apparent lack of dialogue between SSA, Central Office and the States. There is a perception among DDS Administrators that, despite their years of experience in the disability program, their input is not highly regarded.

5. What are the conditions of Federal-State relations in administering the disability program, and what steps can be taken to improve the development and implementation of budgetary and adjudicative policy?

The administration of the SS program is an extremely difficult task. SSA is responsible for assuring that the Disability programs are uniformly administered. However, each DDS is unique. Geography and demographics vary widely between States and these factors impact on costs in unexpected ways. State laws and practices control many administrative aspects of DDS operations. The personnel employed by DDS's are State employees who receive direction from various levels of Government. Conflicts between SSA directives and State laws and practices are not infrequent. This situation is invariably inconvenient to managers in both the Federal and State sectors. Nevertheless, and despite some significant problems, the existing Federal/State relationship is workable. Our experience shows it to work best when knowledge is substituted for suppositions or presumptions, and when there is a spirit of cooperation and mutual respect.

In addition to responding to the questions that we have been asked, NADE would like to take this opportunity to express a concern of our own about the long range implications of the current funding and staffing reductions.

The adjudication of Social Security Disability Claims is an extremely complex task. Disability examiners are routinely required to deal with the interplay of abstract medical, legal and vocational concepts. It takes a year before a new disability examiner is able to become minimally productive. We are concerned that short term monetary gains resulting from the staffing freeze, because of a lack of experienced examiners, in the long run will result in an inability to provide accurate and timely decisions to the disabled population that we all serve.

Chairman JACOBS. Thank you very much.
Ms. Lucas.

STATEMENT OF LAMONA H. LUCAS, DIRECTOR, ALABAMA DIVISION OF REHABILITATION AND CRIPPLED CHILDREN SERVICE, AND SECRETARY-TREASURER, COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION, ACCOMPANIED BY JIM HANCOCK, DEPUTY DIRECTOR, DISABILITY DETERMINATION DIVISION, INDIANA DEPARTMENT OF HUMAN SERVICES

Ms. LUCAS. My name is Lamona Lucas and I represent the Council of State Administrators of Vocational Rehabilitation.

The CSAVR is an organization whose membership is comprised of the directors of State rehabilitation agencies in all 50 States. In 37 States, the Social Security disability determination function is performed by a component of the Vocational Rehabilitation Agencies.

The CSAVR stimulates innovative initiatives in rehabilitation and serves as a liaison with the Rehabilitation Services Administration and the Social Security Administration.

Much of the work of the council is performed through the standing committees, such as the one on disability determination services. The committee consists of one DDS director from each of the 10 regions of SSA, as well as several State rehabilitation directors.

On behalf of the council, it is my pleasure to respond specifically to each of the five issues on which the committee has sought testimony.

Have the SSA restrictions jeopardized the State agencies ability to properly implement the provisions of the Social Security Disability Amendments of 1984?

I would like to cite two instances. One is that States have been unable to participate in the face-to-face demonstration projects due to lack of staffing. And the resumption of the processing of continuing disability review cases has been impossible in some cases because staffing was sufficient only to process new applications and a partial CDR workload.

The CSAVR undertook a small survey to determine the difference between the amounts that the States have requested from SSA and the amounts that SSA requested from Congress.

The DDS budget process is essentially a workload driven process. SSA provides the projected workloads and the States submit budget requests that identify the workpower, productivity, and identify the total costs.

This year the States requested $840.7 million and SSA intends to provide $754 million. That is 89.7 percent of the amount requested by the States.

There are two remaining problems that I would like to cite. One is that the SSA's persistent use of the line item control of the budget, including workyears and medical costs, significantly reduces the States' flexibility in managing the program. We have absolutely no difficulty with the philosophy of improving service to the clients or cutting costs and making every effort to narrow the productivity gaps among the States. But the use of the line item control of the budget restricts management's flexibility to achieve these goals.

There has been little or no opportunity for negotiation or meaningful discussion. The States have simply been given the amounts which many consider to be inadequate with insufficient explanation or suggestions of how to adjust procedures in order to conform.

We would also like to mention that the newly created Federal DDS consumes resources that could be utilized by the States and recently the SSA has requested that executives or workers be loaned. The CSAVR feels that the States, because of the severe staffing reductions imposed by SSA, are not in a position to loan out scarce personnel and that the remaining staff should continue to work in the States to serve the needs of the States' own claimants.

No. 2, how have the State agencies responded to these budgetary constraints, and has this led to any deterioration in quality?

The quality of DDS decisions, as measured by SSA case reviews, continues to be high. However, you have already heard there is a subjective feeling that in the long run quality will be weakened and the program will be weakened.

The States have responded in different ways and some States are able to keep up their production and do not feel that quality is jeopardized, while others have very serious reservations about the possible adverse effects on the program. They feel that the gains in productivity are being achieved at the expense of accuracy, quality of service to applicants, and only through heroic and unsustainable efforts of staff.

Virtually eliminated are refresher training of examiners and physicians, public relations to physicians in hospitals, critical positions not related directly to productivity have been sacrificed, such as training and quality assurance. This will inevitably result in deterioration of both quality and productivity 1 or 2 years into the future.

Chairman JACOBS. Ms. Lucas, the balance of your statement will be included in the record.

[The prepared statement follows:]

Statement of the

COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

The Council of State Administrators of Vocational Rehabilitation (CSAVR) is an organization comprised of the chief administrative officers of the State and Territorial Agencies providing comprehensive vocational rehabilitation services to persons with mental and/or physical disabilities, pursuant to the Rehabilitation Act of 1973, as amended.

In thirty-seven states, the Social Security Disability Determination function is performed by a component of the Vocational Rehabilitation Agency.

Among other functions, the CSAVR shares information betweeen states, stimulates innovative initiatives in Rehabilitation, and serves as a liaison with the Rehabilitation Services Administration (RSA) and the Social Security Administration (SSA).

Much of the work of the Council is performed through Standing Committees such as the Committee on Disability Determination Services. This Committee consists of one Disability Determination Service (DDS) Director for each of the ten regional areas of the SSA, as well as several State Rehabilitation Agency Directors.

The Council, in this Statement, will respond to each of the issues on which your Subcommittee has sought testimony.

(1) HAVE THE SEVERE RESTRICTIONS PLACED BY SSA ON STATE AGENCY FUNDING AND STAFFING LEVELS JEOPARDIZED THE ABILITY OF THE STATE AGENCIES TO PROPERLY IMPLEMENT THE PROVISIONS OF THE SOCIAL SECURITY DISABILITY AMENDMENTS OF 1984?

Two of the requirements of recent legislation amending the Social Security Disability Program that have been negatively affected by resource reduction are Face-to-Face Demonstration Projects and the resumption of the processing of Continuing Disability Review (CDR) Cases.

Some states that originally had planned to participate in the Demonstration Projects withdrew because sufficient staff would not be available. Many states are not able to keep up with the flow of incoming CDR cases because the current staff and funding levels are sufficient only to process new applications and a partial CDR workload.

In order to quantify the extent of the shortfall of resources for administering the Disability Program, the CSAVR undertook a survey of the states to determine the difference between the amounts that the states had requested from the SSA and the amount that SSA requested from the Congress.

The DDS Budget Process is essentially a workload driven process. Once SSA provides the projected workloads, the states submit budget requests that identify the workpower, productivity, and total costs necessary to process the workload.

For Fiscal Year 1988, SSA estimated to the states a workload of about 2,429,000 cases.

The states, using a budget process devised and overseen by SSA, estimated that the cost of processing this workload according to the standards created by the Social Security Disability Amendments of 1984 would be approximately $840.7 million.

Still, SSA intends to provide to the states only $754 million, or 89.7% of the amount requested by the states.

SSA's recent recognition that the states need to have a yearly budget advisory amount (as opposed to a string of quarterly amounts), is a very positive factor.

However, aside from the actual amount of funds provided by SSA, there are two remaining problems that limit the states' ability to effectively manage funds to produce the desired results.

First, there is SSA's persistent use of Line Item Control of the budget including the workyears and medical costs. This significantly reduces the states' flexibility in managing the program. While the CSAVR has no difficulty with the philosophy of improving service to disabled people and making every effort to reduce costs as well as narrowing productivity gaps among the states, the use of the Line Item Control concept restricts management's flexibility to achieve these goals.

Second, for Fiscal Year 1988, there has been little opportunity for negotiation of any other meaningful discussion between the states and SSA regarding the difference between the amounts requested by the states and provided by SSA. The states have simply been given amounts which many consider to be inadequate with insufficient explanation or suggestions as to how to adjust procedures in order to conform to the reduced amounts.

Relative to the subject of Budget Limitations, the CSAVR would like to comment on SSA's recent initiative of having created a component within SSA Central Office which develops and adjudicates Disability Cases in much the same manner as the State Agencies do.

This "FEDERAL DDS" consumes resources which could otherwise be provided to the states in order to permit administration of the program as required by the Disability Amendments of 1984.

Further, SSA has recently requested that certain states "loan" experienced employees to the Federal DDS for extended periods.

The CSAVR strongly believes that the States, because of the severe staffing reductions imposed by SSA, are not in a position to loan out scarce personnel, and that the remaining staff should continue to work in the States to serve the needs of the states' own claimants.

(2) HOW HAVE THE STATE AGENCIES RESPONDED TO THESE BUDGETARY CONSTRAINTS, AND HAS THIS LED TO ANY DETERIORATION IN THE QUALITY AND THOROUGHNESS OF THE DISABILITY CASE DEVELOPMENT, DOCUMENTATION, AND REVIEW?

Although the "quality" of DDS decisions, as measured by SSA case review, continues to be high, there is a subjective belief among many DDS and Vocational Rehabilitation Agency Directors that case documentation has deteriorated as a result of the restriction on funding for the purchase of Consultative Examinations (CE's) and the limitation on staff time for the acquisition and analysis of Medical Evidence of Record.

The states have responded in different ways and have shown wide variation in their ability to cope with SSA's funding restrictions.

With regard to the productivity increase requirements, for example, the states seem to fall into two groups. One group of states is achieving or exceeding the productivity goals while expressing confidence that their development, documentation, and accuracy of adjudication has not been affected. Other states have increased their productivity to the point where they are performing at or near the productivity goals, but still have serious reservations about possible adverse effects.

Many state administrators believe that these gains in productivity are being achieved at the expense of accuracy and quality service to the applicants, and that they are only being achieved through the heroic (and, therefore, unsustainable) efforts of the staff.

These factors, plus certain organizational changes, carry substantial risk to the ability to administer the program effectively in the future.

Such organizational changes include the suspension of much of the discretionary uses of time (such as refresher training of examiners and physicians and public relations visits to physicians and hospitals in the field) and taking employees out of positions that are important but not directly productive (such as specialists in training and in quality assurance review).

Such changes are quite effective at achieving temporary increases in productivity, but will inevitably result in deterioration of both quality and productivity one or two years in the future.

Any discussion of how the states have responded to funding reductions would not be complete without and accompanying reference to how the SSA has failed to respond.

Soon after SSA announced the substantial funding reductions for FY 1987 and the simultaneous increases in workload, SSA Officials declared that doing more with less would be made possible though "Workload Simplification."

"Workload Simplification," according to the SSA, was to have made higher levels of productivity possible by reducing the amount of time and effort required for the completion of each case. No compromise in thoroughness or quality was contemplated, rather, "Workload Simplification" would be designed to reduce the tedious and cumbersome technical aspects of case completion that SSA had permitted to accumulate through the years. As of today, with one minor exception, SSA has made virtually no progress implementing any "Workload Simplification" changes that effect the operation of the State DDS Agencies.

In other words, while requiring the states to process more cases with less funding and staff, SSA has not fulfilled its part of the bargain.

(3) ARE SSA'S PRODUCTIVITY GUIDELINES REALISTIC, AND IS THE METHOD SSA UTILIZES TO MEASURE PRODUCTIVITY ACCURATE, CONSISTENT, OR NATIONALLY UNIFORM? IF NOT, HOW COULD THESE PRODUCTIVITY STANDARDS BE IMPROVED?

As I mentioned previously, the productivity goals appear to be realistic for some States in view of the fact that these States are achieving the goals while maintaining confidence in the integrity and effectiveness of their case processing. Other States are continuing to experience difficulty in achieving goals, and are concerned about the effect on quality service. In the CSAVR sponsored survey mentioned earlier, the States were asked about their expectations for maximum realistic productivity for Fiscal Year 1988. The States cumulatively estimate a National productivity of about 193 while SSA has mandated a national productivity of about 211.

The CSAVR believes that the desire of SSA to increase productivity, as measured by the Production Per Workyear (PPWY) index, will result in the Program being one to two years behind in its ability to effectively utilize additional resources, should they become available, due to the loss of experienced staff and the inability to replace them.

A minimum of one year is required for a new Disability Examiner to become a totally productive employee. In the event of sudden significant increases in the workload or sudden loss of additional staff, the Program would inevitably experience a serious compromise in quality, processing time, and production until such time as staff could be hired and trained.

The matter of the accuracy and consistency of the current Productivity Measurement technique is a separate issue. The technique consists of dividing the number of cleared cases by the number of equivalent full-time employees used by the agency.

This index, called "Production Per Workyear" or PPWY, gives a rough indication of productivity. Unfortunately, the formula is compromised by at least three factors.

First, not all cases are of equal difficulty. CDR cases, for example, are more difficult and require more time for completion than initial level cases. SSA's current formula does not account for this and those states that are processing the more difficult caseloads are penalized.

Second, there is a variation in the way that states report employees who do not perform activities directly related to case productions. Some states pay such employees directly and they are counted in the Productivity figures, while other states pay them through indirect costs and do not include them when factoring PPWY.

Third, some states have certain tasks (for example, transcription of dictated medical reports) performed by employees while others contract with outside service agencies for such work. Since paid hours count against PPWY and purchased outside services do not, states are not treated consistently.

The Subcommittee asked how the Productivity measurement could be improved.

About six years ago, SSA began to develop a sophisticated computerized system designed to facilitate analysis of the expenditures of the state agencies and to relate performance variable to cost variables.

This System, called the "Cost Effectiveness Management System" (or CEMS) has potential, but its implementation has been extremely slow.

CEMS, once fully implemented, may have the ability to remedy the problems of productivity measurement as described above.

Because CEMS has the ability to "weight" some of the variables that contribute to the relative cost and difficulty of processing certain types of cases and because it is also able to adjust for geographic variations in the prevailing costs of doing business, SSA should consider replacing its Productivity Measurement (currently expressed in the number of cases produced by the average worker) with the more meaningful and understandable indicator of "Adjusted Cost Per Weighted Case."

This figure would be the total expenditures of the state adjusted for prevailing local costs divided by the total number of cases processed weighted for the difficulty of the cases. This would measure the cost to SSA of contracting the Disability Determination function to the States.

(4) DOES A CLIMATE OF CRISIS AND DISRUPTION CONTINUE TO PLAGUE THE DAY-TO-DAY ADMINISTRATION OF THE DISABILITY PROGRAM, AND, IF SO, HOW CAN ORDER AND STABILITY--THE KEY OBJECTIVES OF THE 1984 LEGISLATION--BE RESTORED TO THE ADMINISTRATIVE PROCESS?

There is an element of disruption related to the speed with which SSA expects states to reduce the levels of expenditures. A major source of disruption in administration of this Program has been the sudden and rather radical swings in the messages that the SSA gives to the states.

For example, most of the states that SSA now considers to be "overstaffed" hired their existing personnel just a year or two ago at the insistence of SSA officials who encouraged "staffing up" in order to implement the Social Security Disability Amendments of 1984.

With a change in SSA Commissioner and other top management staff, the States were suddenly ordered to "staff down", and inadequate time was permitted to do so.

Other changes in SSA instructions have been equally as extreme. Even if SSA's current expectations are viewed as reasonable and attainable when considered in isolation, they become part of a large picture of crisis, disruption, and instability when considered in conjunction with earlier SSA directives.

To the extent that a crisis environment exists, another contribution has been SSA's management of the CDR workload for Fiscal Year 1987.

SSA insisted that the originally budgeted numbers to be processed even though full scale resumption of the workload was delayed until well into the Fiscal Year because of SSA's inability to get the cases out into the field in a timely manner. After having sent out very few cases in the first five months or so, field offices were then pressured to process a large volume of cases in order to make up for lost time.

As a result, many State DDS Units are holding CDR cases for recipients who have been advised that their Review would be conducted and completed soon.

This produces needless delay and consequent anxiety for the individual recipients affected.

Order and stability can be restored to this program by moderating the rate and extent to which SSA changes its mind on important program matters including funding. When changes are made, more time is needed to effect them on the state level. The SSA should identify and use better methods to smooth out the flow of CDR cases so that large numbers of cases do not reach the field all at once.

(5) WHAT IS THE CONDITION OF FEDERAL-STATE RELATIONS IN ADMINISTERING THE DISABILITY PROGRAM, AND WHAT STEPS CAN BE TAKEN TO IMPROVE THE DEVELOPMENT AND IMPLEMENTATION OF BUDGETARY AND ADJUDICATIVE POLICY?

At present, the relationship can be described as adversarial and characterized by some resentment and distrust.

On some matters, the SSA has not lived up to its commitments. For example, "Workload Simplification" has not materilized and the SSA has been unable to effectuate a smooth and even flow of CDR cases. Many states do not agree that the funding restrictions are wise or reasonable, and even if they were, the SSA has expected this change to occur too fast.

Many of those states that have been able to live within the funding restrictions while maintaining good quality were able to do so only because they disregarded SSA's earlier instructions to acquire additional staff.

The relationship between SSA and the States was further deteriorated by a recent surprising and rather threatening announcement by Commissioner Hardy to the State Administrators.

After having restricted staffing authorizations to levels well below the actual number of staff on hand at the beginning of the Fiscal Year, and after having previously quite specifically indicated that the States were not expected to impose "reductions in force" in order to comply with the staffing limits, Commissioner Hardy suddenly announced that those states who did not staff down to the targets were "courting difficult times" and would be subject to Federal audit exceptions."

The vague yet ominous nature of the Commissioner's announcement and its apparent contradiction of earlier statements served to heighten the level of distrust.

The Subcommittee asked what steps could be taken to improve policy development.

In addition to moderating the sudden and extreme changes in program funding and philosophy, another positive step would be to increase the level of State Agency participation in the development and revision of policy and procedures. Under previous Commissioners, there was abundant and healthy interchange of ideas and perspectives between State and Central Office personnel. The natural outcome of such discussion was to bring to the attention of the Central Office policy makers the practical day-to-day expereince of those who actually administer the programs in the field. Such contracts are critically needed because very few Central Office personnel have any experience at all in State Agencies.

Under the current administration, such face-to-face exchanges between Central Office staff and field personnel have been drastically reduced.

The CSAVR, through its Disability Determination Committee, stands ready to provide such consultation, advice, and assistance to SSA Officials on the widest range of issues concerning day-to-day administration of the Program.

Presented by:

Lamona H. Lucas, Director
Alabama Division of Rehabilitation
and Crippled Children Service

Accompanied by:

Jean Merritt, Commissioner
Indiana Department of Human
Services

Jim Hancock, Deputy Director
Indiana Disability Determination Division

Chairman **Jacobs**. Mr. Hancock.

Mr. **Hancock**. I have nothing to add to the other prepared testimony, Mr. Chairman.

In addition to representing CSAVR, I am also the DDS director from the State of Indiana and I would like to request that later, in writing, I put in the record the presumptive determination rate of the Indiana DDS.

It is not 75 percent. It is consistently run at or near the national average, which I believe is about 20 percent.

Chairman **Jacobs**. We shall accept that into the record.

[The following was subsequently received:]

State of Indiana • Department of Human Services
251 North Illinois St., P. O. Box 7083, Indianapolis, IN 46207-7083, 317-232-7000
1-800-545-7763
Robert D. Orr, Governor
Jean Merritt, Commissioner

October 26, 1987

Honorable Andy Jacobs, Jr.
House of Representatives
10th District
46 East Ohio Street
Indianapolis, IN 46204

Dear Congressman ~~Jacobs:~~ Andy

Your leadership of the Subcommittee on Social Security is most appreciated. The impact on the national level has been very welcome. As the Commissioner of the Indiana Department of Human Services (IDHS), I have been following the work of the Subcommittee with particular interest because it directly impacts on the Hoosiers served by the Department.

I was scheduled to testify before the October 6, 1987 meeting of the Subcommittee because it focused on the Disability Determination Program. Unfortunately, I was ill and unable to be in attendance. However, I know that the positions of the Council of State Administrators of Vocational Rehabilitation were well represented by Lamona Lucas, the Director of the Alabama Division of Rehabilitation and Crippled Children Services, and Jim Hancock, the Director of the Indiana Disability Determination Office.

The Disability Program has been hit with severe cuts in resources. In reading the written testimony, it is clear that the impact of the cuts was thoroughly presented to the Committee. However, I was concerned about the testimony of Janice Cocquyt, who is a Social Security Claims Representative from the Akron, Ohio, Social Security Field Office. She addressed her comments to the Subcommittee on the effects of the federal resource reductions on Ohio and Indiana. She stated that a Social Security Field Representative in Indiana had told her that staffing for the DDS's was based on mean processing time for doing cases. Further she stated that Indiana was making presumptive determinations on 75 percent of the Title XVI cases in order to get more staff. Indiana's presumptive determination rate is 12 percent, which is below the 20 percent goal that has been established by the Social Security Administration. In addition, neither presumptive determinations nor processing time have any impact on the staffing levels provided to the states by the Social Security Administration. These two points are obvious to anyone with even a passing knowledge of the disability program. Over the past three years, the Indiana Disability Determination Office has established a high level of services to Disabled Hoosiers. Our quality, productivity, and processing time have remained very good, despite the resource cuts. In February of this year, the Indiana DDO received a citation from the Regional Social Security Administration Commissioner because of our improved level of performance. I am respectfully requesting that this letter be made a part of the record in order to correct the previously mentioned inaccurate testimony.

I appreciate your attention to this matter and look forward to working with you so that we can better serve Hoosiers.

Sincerely,

Jean Merritt, Commissioner
Indiana Department of Human Services

JM/bc

cc: Joe Owens

Chairman **Jacobs**. Mr. Archer will inquire.

Mr. **Archer**. I am just curious as to what each of you would think about H.R. 2117, which as I mentioned I have introduced. It would permit the Secretary of HHS to federalize the State agency operations to assure effective, equitable and uniform administration of the program?

Do you think that would be helpful?

Mr. **Hancock**. It is a question that has been discussed and debated for a long period of time and there are good arguments on both sides. Representing CSAVR, the feeling is that the DDS' belong in the State, closer to the people who we are serving. I think the concern would be, and the opinion would be, of CSAVR that it belong in the States.

Ms. **Lucas**. That is my personal view.

Mr. **Tschetter**. Again, as Mr. Hancock indicated, this has been something that has been discussed as long as I have been involved in the program also, in reference to the federalization of the DDS'. As a position, NADE, in the past has taken a position of federalization of the disability program.

This has been something that has not been discussed and has been, in recent years for one reason or another which I really cannot get into, but I think it does have good points, in reference to the possibility of consistency and the possibility that if there a place in geographical preference instead of matching State by State because some geographical concerns will go over into other States if there is a combination of the States that are involved.

I would hate to see it used as a threatening tool to the DDS because, in a way, SSA can make their statistics feel as to what they want to show—I mean, they are the ones that judge the quality and are also the ones that are setting the rules.

Mr. **Archer**. How, in your opinion, is it a threatening tool? I certainly, in introducing this legislation, do not intend to threaten anybody. I think we should all search for the best possible way to implement the program. How is it threatening?

Mr. **Tschetter**. Probably the biggest feeling on that is maybe just a little bit of personal paranoia as to other things that have come down through the regulatory process and how they are finally spelled out once they have gone through the regulatory process. It is that little bit of fear, I guess, too, and this is not in saying that federalization of the program is a bad idea, but it is just a fear of is that something SSA can hold over any DDS?

Because if they wanted to, I would say that SSA can make any DDS fit a certain pattern through quality reviews.

Mr. **Archer**. Thank you very much.

Chairman **Jacobs**. The committee is grateful for the panel's contribution. Thank you very much for your appearance.

The next panel consists of the American Association of Retired Persons, Robert Maxwell; Alliance for Social Security Disability Recipients, Eileen Sweeney; National Organization of Social Security Claimants', Nancy Shor; and Clifford Weisberg.

Mr. Maxwell.

STATEMENT OF ROBERT B. MAXWELL, VICE PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. MAXWELL. Mr. Chairman, I am Bob Maxwell from the American Association of Retired Persons. We represent the interests of about 26 million members, most of whom are age 50 and over. We are really pleased to testify in this hearing on the condition of the Social Security disability program.

We want to commend you for your continuing interest in Social Security matters.

These are issues that not only affect retired persons and workers but also current workers and their families. Entitlement to disability insurance, like old age and survivors insurance is a protection that workers earn for themselves and their families by paying Social Security taxes during their working years.

While SSDI covers disabled workers of any age, it is particularly important to those aged 50 and above. These workers are less likely to recover from a disability or become reemployed after a disability.

AARP has a long standing concern about the administration of the program, but of late we have been hearing about increasing problems in two areas. The procedure for filing for a benefit and SSA's implementation of the 1984 legislation that prescribed new standards for the continuing disability reviews.

As a result of Social Security Administration's staff reductions, DI applicants do not really receive proper assistance in completing very complex forms needed to apply for benefits. This creates a problem for all applicants but it is particularly burdensome for mentally impaired DI applicants who may not understand the directions.

Completed applications and other relevant material are sent to the disability determination service, which is a State agency fully funded by the Social Security trust funds. But the DDS does both initial reviews of claims and the reconsiderations.

Today these offices are facing a backlog of cases as the continuing disability reviews resume. Yet, Federal Disability Program outlays have not increased to reflect the DDS' increasing workload.

Moreover, SSA has mandated increases in the district office and DDS workload requirements from 165 cases per employee to 195 cases. Thus, it is difficult if not impossible for States to administer SSDI in accord with the requirements of the 1984 legislation.

AARP is concerned that the tendency to mandate larger workloads without a corresponding increase in personnel and other resources, could lead to even less accurate case work and eventually to a situation similar to that that existed prior to the 1984 amendments.

A system that defines its success by sheer volume, without an eye toward accuracy, will have a truly harmful effect on numerous disabled Americans and their families. Congress, too, is becoming alarmed about the administration of SSDI. Almost 40 Congressmen have joined with Representative Barney Frank in support of House Concurrent Resolution 35 which seeks to ensure the efficient and compassionate management of the SSDI program.

Based on reports we have heard about the SSDI program, the association recommends that SSA could do the following: one, study what an SSDI case load level should be for both accuracy and system efficiency; two, slow down requirements for case load increases until there is enough staff to do quality work; and three, authorize enough money and staff to ensure accurate case work and system efficiency.

There is no question that AARP supports improved productivity and SSDI management. Yet, unless Congress and the Social Security Administration respond to the growing concerns about the way the DI program, and the 1984 amendments are being administered, we risk the mishandling of vital protection for thousands of disabled Americans as well as the continued erosion of public confidence in the integrity and fairness of our great social insurance program.

Thank you, Mr. Chairman, for permitting us to testify.

[The statement of Mr. Maxwell follows:]

STATEMENT OF THE
AMERICAN ASSOCIATION OF RETIRED PERSONS

The American Association of Retired Persons (AARP) is the nation's largest membership organization, representing the interests of over 26 million members aged 50 and above. The Association is pleased to testify today on the condition of state agencies that determine disability under the Social Security Disability Insurance (SSDI) program. AARP commends the Subcommittee Chairman for his on-going interest in Social Security issues--issues that affect not only retired workers, but also current workers and their families. Entitlement to Disability Insurance (DI), like Old Age and Survivors Insurance (OASI), is a protection that workers earn for themselves and their families by paying Social Security taxes during their working years.

SSDI covers disabled workers of any age, but it is particularly important to those aged 50 and above. Of every 1,000 working adults, 165 are disabled. The majority of those disabled workers are between the ages of 55 and 60. For these older disabled workers, recovery from a disability is less likely, and reemployment after a disability is particularly difficult.

Given the large stake that older persons have in DI, the administration and the decision making process of this program have been long standing Association concerns. However, our interest became fear in the period between 1980 and 1984.

This is a chronology of what has happened to the program since 1979:

- In 1979, a study done by the Social Security Administration showed that a portion of the disability beneficiaries were receiving benefits for which they were no longer eligible;
- In 1980, Congress responded by enacting legislation that required a review of all but the most disabled beneficiaries to determine whether they still qualified for the program;
- In March 1981, the Continuing Disability Review (CDR) process began and ultimately terminated improperly the benefits of thousands of disabled persons. Over 495,000 persons were unceremoniously removed from the rolls... about 214,000 persons were restored to disabled status eventually; however, the lengthy appeals process is very difficult for an already disabled person;
- In April of 1984, the whole CDR process was called to a halt by the Secretary of Health and Human Services.
- By October of 1984 Congress, concerned about the erosion of public confidence in the system, passed comprehensive legislation that prescribed a standard of review and required the Secretary to prepare regulations.
- These regulations were implemented in December 1986.

The 1984 legislation established three important protections:

1) benefits may be terminated for a disabled beneficiary only if there is substantial evidence of medical improvement in the

individual's condition, and evidence the individual is able to engage in substantial gainful activity (SGA);

2) multiple impairments should be considered in determining overall disability; and

3) benefits may be continued through appeal of a termination up to the Administrative Law Judge level.

Today, with the regulations complete and resumption of CDR's, the Association believes extra care must be taken to ensure that workers rights are protected and that the 1984 amendments are properly implemented. Unfortunately, AARP has been hearing about too many problems regarding recent implementation efforts.

For an individual, the procedure for getting a benefit begins at the District Social Security office (DO), where the initial application is made. Non-medical eligibility factors such as quarters of coverage and recency of work are checked here. If the applicant meets the non-medical requirements, the application, medical records provided by the applicant, and background information from the district office interview are all forwarded to the Disability Determination Service (DDS) where the medical determination process is focused.

This crucial first step, as well as others, in the disability process are being impeded by staff reductions at the Social Security Administration (SSA). The DI application is quite complex and many individuals need assistance in completing the form. However, some Social Security employees, responding to the pressures of the job and quantitative job performance standards, are spending less time with applicants. In some instances, they do not provide clear answers to applicant's questions. Also, we know that in at least one state, (Maine) DI applicants are being asked questions incorrectly or incompletely. Instead of being asked, "How many doctors have you seen in the last two years?" which would elicit a complete and helpful response, applicants are simply asked, "Who is your doctor?"

In short, DI applicants are being disadvantaged. As one congressional caseworker commented:

> "They [SSA] have tendency to rush with clients who have limited understanding of the program, leaving them confused. [They] too often give a quick answer that is unresearched and therefore wrong."

In some cases, the result of this situation could be improper denial of benefits.

AARP is also disturbed by reports of SSA employees encouraging applicants to complete the required paperwork outside the office. This creates problems for all applicants, but is particularly difficult for the mentally impaired who may not understand the directions (either verbal or written).

The second step in the process is completed by the Disability Determination Service (DDS). Each state has a DDS wholly funded by SSA. It is here that the important and often tedious process of both initial reviews and reconsideration of claims are made.

Today, these offices are facing a backlog of cases as the Continuing Disability Reviews resume. Unfortunately, Federal disability program outlays do not reflect these state agencies' increasing workload. Federal payments to DDS's increased from

$666 million in FY 1985 to $755 million in FY 1986. However, in FY 1987 the DDS budget was decreased to $741 million, and the FY 1988 payments are expected to be close to those of 1987.

With a smaller budget than in 1986, with a need for training in the new Disability Insurance regulations, with the start up pressures of old and new cases, and the expanded District Office and Disability Determination Service workload requirements--this year, the DDS employee caseload is being increased from 165 cases per employee to 195 cases per employee per year--it is difficult, if not impossible, for states to administer SSDI in accord with the requirements of the 1984 legislation.

The comments of Congressional caseworkers who were surveyed by the Save our Security Coalition, illustrate the consequences of these cuts:

- " SSA was slow in approving [a benefit] for a totally destitute heart patient. The patient had more attacks and died. The next day SSA agreed to pay for medication that would have saved his life. [The real] problem is in interpretation of regulations and delays between [appeals and] decisions."

- [We had a] "...recent case of a young man denied disability for bone marrow cancer.He died a week after he was finally awarded [disability benefits].

- In the last year I've assisted two claimants with requests for reconsideration who were terminally ill with cancer with anticipated survival of no more than a year who were advised to seek less strenuous work. This seems to occur frequently also with middle-aged heart patients, both in cases of inoperable conditions and cases of multiple surgeries with no improvement."

- "The Division of Disability Determinations didn't fully investigate a rejected case centering only on one physical problem instead of on all of them. Therefore, the person was considered well enough to return to work, but she is terminal."

These and other cases illustrate a growing SSA tendency to mandate larger workloads without a corresponding increase in personnel and other resources. This will lead to even less accurate casework, and eventually situation similar to that of 1981 could occur. A system that defines its success by sheer volume without an eye toward accuracy will have a truly harmful effect on numerous disabled Americans and their families.

Congress too is concerned about the administration of SSDI. Almost forty Congressmen have joined with Representative Frank in support on HConRes 35, which seeks to ensure the efficient and compassionate management of the SSDI program.

It is important to note that while our testimony focuses on the funding and staff levels that affect the process of becoming a DI beneficiary, AARP is also aware of the mishandling of medical improvement or mental impairment cases. For example, one congressional caseworker told us that "a patient is up for a psychological re-evaluation who cannot speak, has had two heart attacks, and a stroke. This re-evaluation is to determine if the patient should stay on disability."

Based on the reports we have heard, the Association recommends that SSA:

- Study what a caseload level should be for both accuracy and system efficiency;
- Slow down requirements for caseload increases until there is enough staff to do quality work; and
- Authorize enough money and staff to assure accurate casework and system efficiency.

There is no question that AARP supports improved productivity in SSDI management. However, to evaluate productivity on numbers alone leaves out the most important consideration-- the individual and his or her case. The lack of quality is why the Congress called a halt to the Continuing Disability Reviews in 1984 and sought to ultimately correct the problems through the 1984 Amendments.

In AARP's view, it is imperative that Congress and the Social Security Administration respond to the growing concerns about the way the DI program and the 1984 legislation are being administered. Without such prompt action, we risk the mishandling of vital protections for thousands of disabled Americans as well as the continued erosion of public confidence in the integrity and fairness of this social insurance program.

Chairman JACOBS. Thank you, sir.

STATEMENT OF EILEEN P. SWEENEY, STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER, ON BEHALF OF THE ALLIANCE OF SOCIAL-SECURITY DISABILITY RECIPIENTS

Ms. SWEENEY. Mr. Chairman, I am Eileen Sweeney. I am a staff attorney at the National Senior Citizens Law Center and I am here today on behalf of my client, the Alliance of Social Security Disability Recipients.

The issues raised in this hearing are of critical importance to disabled Americans, both those already receiving benefits and those who are applying to receive benefits. I think in 1984 we all hoped, perhaps overoptimistically, that the 1984 amendments would signal an end to the arbitrary practices of the Social Security Administration. However, as others are testifying today, that simply has not been the case.

Instead, after a hiatus in which SSA regrouped, we are once again seeing the types of problems that result in the issuance of shoddy, low quality decisions. The problems which these practices create for disabled individuals are enormous. They include months, sometimes years, without benefits to which they are legally entitled; further deterioration of their disabling conditions due to lack of access to medical care; and endless hoops to jump through on the path to eventually possibly securing their benefits.

Once they earn benefit status, they have the knowledge or the fear that they may be arbitrarily terminated at some point down the road.

In my written statement, I describe a number of the problems which currently exist and I will only briefly summarize them here. First, the jury is out on how the continuing disability reviews are going. As the GAO has found, SSA has skewed the results by focusing for quite a while almost exclusively on the "MINE" cases.

Those are the people who are so seriously impaired that SSA categorizes them as not expected to improve and reviews them only infrequently. Not surprisingly, SSA found that almost all of these people were entitled to have their benefits continued.

Since the GAO's report, SSA's work has swung in the opposite direction, to the medical improvement expected or MIE cases. However, because in the last couple of years SSA has expanded the MIE definition, it now includes many people who are really MIP's, the medical improvement possible people. This includes many mentally ill people.

As a result, it is impossible to know from SSA's data what they are really doing in the CDR's. There are numerous problems with the medical improvement standard as SSA has implemented it, not as the Congress enacted it. Unfortunately, it is likely that we will begin to see the consequences of those problems in the near future.

As a result, I urge the subcommittee to closely monitor the CDR process but not act at this time in reaching any final conclusions as to its efficacy.

It is very clear that SSA's commitment to properly adjudicating the cases of the mentally impaired individuals has slipped drastically. As I discuss in my statement, SSA is no longer securing necessary documentation, has created so many budget saving shortcuts that even its own Associate Commissioner for Assessment has indicated that she believes that many of the mentally impaired people's cases which are being denied should be allowances.

In both the mental and physical impairment cases, SSA is violating the statute and its own regulations with regard as to who is to complete the residual functional capacity evaluation. As things currently stand, SSA is telling its examiners to fill them out, leaving only the physician's signature to be filled in.

Because the DDS's have been forced to cut back on the physicians they hire, those who do still work for them are overwhelmed and unlikely to ever look at the file prior to making the RFC evaluation. In fact, they do not make the evaluation, they just sign it.

As discussed in my written statement, this practice is clearly illegal.

While I discuss a number of problems with the standards for adjudicating disability in my statement, two procedural problems deserve special mention here. Since 1980, Congress has required SSA to provide reasons for its negative decisions in the notices it issues to disabled people. In clear violation of that statute, SSA is cutting back to the point of eliminating the portions of its denials and terminations notices which describe the reasons for the decision.

This just adds to the confusion and hardship for the disabled person who reads the notice. It also is administratively incredibly short sighted. Some people seeking the notice will seek out an explanation from SSA anyway, and others may appeal when they might not have if they knew the reasons for the decision.

Second, and perhaps most importantly, the subcommittee should consider the report of the California auditor general. He found that the California DDS had cheated in drawing its random sample for performance reviews. While that is obviously unacceptable, the most damning portion of the report focuses on the pressures which SSA has placed on the DDS's and on SSA's lack of incentive to discover such violations because it behooves SSA to have records which reflect that everything is just swell in the field, regardless of the reality.

In a related area, the Office of Hearings and Appeals draft proposed regulations on attorney's fees are totally out of line with the actions this subcommittee has already taken this year. They simply reinforce the fact that SSA is working steadfastly to develop mechanisms to assure that no disabled person is ever able to secure private attorney representation before SSA.

Given the complexity of the process and SSA's continued efforts to subvert congressional intent in this program, it is critical that there be legislative reform immediately on this issue. The subcommittee's actions earlier this year are well designed to address the problem. SSA and the Secretary should be urged not to issue the drafted proposed regulation.

Finally, from everything I have been hearing about what is going on at SSA these days, I think it is incredibly commendable that any SSA employee appeared here today or any DDS program appeared here today. My sense is that they are at great risk for their programs or their job promotions by appearing. I think it is a reflection of how strongly they feel about the problems that exist there, that they would appear before this committee today.

Thank you.

[The statement of Ms. Sweeney follows:]

STATEMENT OF EILEEN P. SWEENEY OF THE NATIONAL SENIOR CITIZENS LAW CENTER, ON BEHALF OF THE ALLIANCE OF SOCIAL SECURITY DISABILITY RECIPIENTS

I am a staff attorney at the National Senior Citizens Law Center (NSCLC).

I am appearing today on behalf of my client, the Alliance of Social Security Disability Recipients. Based in North Carolina and led by Dona Montgomery, the Alliance has over 4,000 members in 18 states. The Alliance was formed in the early 1980's by disabled individuals, their families and friends, to advocate against the disability benefit terminations which eventually led to the passage of P.L. 98-460, the Social Security Disability Reform Act of 1984. The Alliance and its members are very concerned about the serious problems which continue to persist for disabled Americans in securing fair, accurate and timely decisions from the Social Security Administration. Their experience is that the Secretary's compliance with the Congress' intentions in P.L. 98-460 has been in some cases at best grudging and, in many other cases, better characterized as clear efforts to subvert the Congress' intent.

NSCLC is a national legal support center funded primarily by the Legal Services Corporation. We also receive funds from the Administration on Aging. We provide legal services and aging advocates with assistance in addressing the legal needs of their elderly and disabled clients. I specialize in Social Security and SSI issues.

My statement today focuses on some of the major problems that persist in the Social Security and SSI disability programs.

Since 1981, review of SSA's disability procedures and policies has tended to fall into two categories: initial application cases and continuing disability reviews (CDRs). For many reasons, the jury is still out on the CDRs. As is discussed below in Section I, while there is good reason to believe that there are serious problems, the bizarre caseload mix chosen by SSA since 1984 in the CDRs precludes definitive analysis.

In addition to correcting the abuses in the CDRs, the 1984 Act also included numerous provisions designed to assure that fair, realistic rules were applied uniformly throughout the administrative process in both initial application and CDR cases. In Section II, I discuss some of problems SSA has created by emphasizing workload production at the expense of quality. In Section III, I discuss some of the problems SSA has created in the standards applied by not properly implementing various provisions of the 1984 Act or by unfairly ignoring or discounting valid and persuasive medical evidence.

Finally, as if these problems were not enough to discourage the disabled, the Commissioner has devised other obstacles to applying for and ultimately securing benefits. These are discussed in Section IV.

All of these problems combine to assure that many eligible disabled people are being denied benefits. They also supply further evidence of the critical need to assure attorney representation in these programs. The provisions passed by this Subcommittee are well-designed to assure representation. This is discussed in Section V.

I. Congress Should Withhold Judgment On The CDRs And Related Provisions

For a number of reasons, SSA has terminated very few people's benefits since 1984. When SSA resumed the CDR process, it decided it would focus largely on the MINE cases. These are the "medical improvement not expected" cases, those individuals whose impairments are so severe and permanent that SSA reviews them only once every 5 to 7 years. SSA did this because they knew few people in this category would be terminated and they hoped to improve their public image. (SSA staff were very clear about this.) And, because these cases could be processed under a more "streamlined" CDR, SSA hoped to process more cases. At the same time, SSA apparently also began to do a few "decision review" (DR) cases. (These are the people in court cases entitled to re-review under §2 of P.L. 98-460.)

Not surprisingly, by late in 1986, the General Accounting Office (GAO) told SSA that its focus on MINE cases, to the exclusion of MIE, MIP[1] and DR cases, was not wise.[2] As a result, recently SSA has focused most of its resources on MIE and DR cases. While SSA has been less than forthcoming about the results of the CDRs, it appears that so far, despite the various deficiencies in the standard as SSA construes it, the allowance rate has been above 80%. However, because SSA's figures are based so heavily on MINE cases and skewed MIE figures, it is virtually impossible to have any confidence about what the CDR allowance rate will look like in the future.

There are many serious deficiencies in the way in which SSA implemented the medical improvement standard.[3] Some of the most basic problems include:

(1) In assessing medical improvement, SSA is not looking at the entire claimant: SSA only looks at impairments which existed at the time of the last favorable review. [20 C.F.R. §404.1594(b)(1).] This raises practical concerns (i.e., what about a related impairment that arises later, what if the person had the impairment but it was not fully documented, what if the person has later developed impairments that should be considered) as well as legal concerns. SSA should not be subdividing the person's impairments. Instead it should simply compare the whole person at the time of the last favorable decision with the person's overall current condition.

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[1] "MIE" is "medical improvement expected." The term is supposed to apply to cases where SSA expects that the person's condition will improve soon. One example would be a person who suffered serious injuries on the job which while expected to last over 12 months, are expected to respond to treatment and improve quickly. In these cases, review is in 6 to 18 months. (It should be noted, however, that it appears that SSA is improperly including some "MIP" cases in the MIE category. As a result, the MIE continuance rates will be inflated by allowances that are really MIP decisions.) "MIP" is "medical improvement possible." These are the cases which receive three year reviews: while it is not expected that the person's condition will improve, it is possible.

[2] "Social Security: Adjusting Continuing Disability Review Priorities," October, 1986 (GAO/HRD-87-4). It notes that the GAO "expressed our concern that claimants with a high probability of medically improving were not given sufficient priority in SSA's CDR workload mix. Also, for court remanded cases and other re-reviews pursuant to the law, we believed that equity required that SSA resolve the eligibility status as promptly as possible to relieve any uncertainty on behalf of these claimants." See also, "Briefing Report: Social Security Disability: Implementation of the Medical Improvement Review Standard," December, 1986 (GAO/HRD-87-3BR).

[3] SSA was required to issue regulations no later than 180 days after the date of enactment, October 9, 1984. SSA issued the proposed regulations on April 30, 1985. 50 Federal Register 18432 (April 30, 1985). The final regulations were issued on December 6, 1985. 50 Federal Register 50118 (December 6, 1985). For a more detailed discussion of the medical improvement standard, and problems in its implementation, see Sweeney, "The New 'Medical Improvement' Standard in Social Security and SSI Disability Cases," 14 Social Security Reporting Service (West) 965-1068.

(2) SSA is relying heavily upon fictional RFCs and reconstructed RFCs: Once SSA has decided that medical improvement has occurred, it will then determine whether the improvement is related to ability to do work. [20 C.F.R. §1594(b)(2).] To make this determination, SSA will compare the person's RFC (residual functional capacity) at the last evaluation with an RFC for just those same impairments at the time of the current evaluation. [20 C.F.R. §1594(b)(3), (7).] Where the person has any additional impairments since the last favorable decision, this later RFC is essentially a fictional, or artificial, evaluation as it pretends to judge a person's RFC based upon only some impairments while excluding others.

(3) Ironically, those who met the Listings last time may benefit least under SSA's version of the standard: If a person's condition was so severe at the time of the last favorable review that SSA held it met the Listing of Impairments, SSA would not have done an RFC evaluation. SSA will determine if the person's condition still meets that old listing. If it does not, SSA will deem the person to have an increased RFC. [20 C.F.R. §404.1594(c)(3)(i).] As a result, it finds that the person has medically improved and that the improvement is related to work. (SSA will then do a current SGA evaluation.) Had the person's condition not met the Listings the last time, SSA would have had to compare the RFCs, not simply deem an increase in RFC. As a result, a person with a slightly less severe impairment will be better able to prove no medical improvement related to ability to work than the person who met the Listing.

(4) And, disabled widows will suffer most: By definition, a disabled widow's impairment(s) must meet or equal a listed impairment before she will be found eligible for benefits. [20 C.F.R. §404.1578.] She will therefore be hurt by the "deemed RFC" rule discussed above. Unlike other disabled beneficiaries, she will also be excluded from having her age considered. SSA has determined that in making the RFC determination in applying the medical improvement standard it will give special consideration to age if the person is over age 50 and has been on the rolls "for a considerable period of time." [20 C.F.R. §404.1594(b)(4)(ii), (iii).] By incorporating consideration of age and time on the rolls into the RFC step, SSA has effectively barred its benefit to a group well-suited to benefit from it: all disabled widows are, by definition, over age 50. Only their "time on the rolls" would be at issue.

Based on these concerns and others, there is every reason to believe that SSA is terminating (or will soon terminate) the benefits of those clearly intended to benefit under the 1984 Act.[4]

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[4] There are two other provisions which clearly have not taken effect in any serious way yet. First, benefits are to be continued through the ALJ stage in termination cases. This provision currently expires on December 31, 1987. That date was chosen on the assumption that the CDRs would have been resumed in 1985 and that, therefore, most, if not all, disabled beneficiaries would have received a CDR decision long before the December 31, 1987 date. While the Alliance urges the Subcommittee to make this provision permanent at some point, it fully supports this Subcommittee's provision in the budget reconciliation process to extend the provision for one year. Second, in 1982, in P.L. 97-455, Congress ordered SSA to have face-to-face hearings at the reconsideration level in termination cases. It is only in the last year that any of these hearings have been held. To date, the experience with them is very limited. As a result, their value is, at best, a matter of conjecture.

II. SSA's Pressure On The DDSs Is Manifesting Itself In Cheating, Violations Of The Statute And SSA's Regulations, And Low-Quality, Inaccurate Decisions

A. The California Auditor General has found that the California DDS interfered with SSA's Quality Assurance random sampling.

In a letter and report, dated February 19, 1987, Thomas W. Hayes, Auditor General of California, very clearly states that DDS staff "have been interfering with the sampling procedures used to randomly select cases for quality assurance review" by SSA, taking out cases with errors. "As a result, the number of errors that the division makes in determining the medical eligibility of California residents for disability benefits is understated. Branch officials within the division were aware of and condoned the practice of substitution."

The report discusses the findings and states that "all but one of the five branches initiated the practice of substituting sample cases within the last 18 months. The fifth branch, Los Angeles West, has had for several years a policy of making substitutions under special circumstances."

The report attributes the practice to:

(i) The "strong sense of competition" in the disability program. It notes that California has been ranked in the bottom half until recently, when it went into the "top 10."

(ii) "The branch staff's lack of regard for the performance rating that measures two components of performance--the accuracy of decisions and the thoroughness of documentation to support decisions."

And, probably most troubling for this federal program:

(iii) "Management's lack of incentive to uncover improper practices that inflate performance ratings. Staff and management at the branch, state, and federal levels all benefit from high performance ratings that reflect favorably on the disability analysts and on overall program management. Both the department and the regional office of the Social Security Administration received the letter that prompted our investigation of this complaint. After conducting cursory investigations, the division official and an official of the Social Security Administration concluded there was no substance to the complaint." (Emphasis added.)

As discussed in the following sections, these pressures are continuing to mount.

B. There are many other problems in the state DDSs which are the result of SSA budget cuts and unrealistic expectations about what DDS staff can do.

Friction is continuing between the state DDSs and SSA. There appear to be at least three major areas of disagreement: (1) the increased caseloads SSA expects each DDS examiner to handle (the increase is due to both staff cuts and caseload increases); (2) reductions in development with greater reliance on consultative examinations even where information has recently been sought from a treating source; and (3) the extent of development required in mental impairment cases. In addition, the SSA pressures appear to be creating pressures within DDSs which are resulting in restrictions being placed upon the independent judgments of DDS medical consultants. Because I assume that the state DDSs appearing before the Subcommittee today will detail these problems further, I highlight only two:

(i) SSA is not properly doing RFCs. The accurate determination of residual functional capacity (RFC) is critical. It must be an individualized assessment. It is the basis for all later decisions made about the individual in the sequential evaluation process. 20 C.F.R. §404.1546 requires that a DDS physician "must assess" RFC. "This assessment is based on all the evidence we have." In addition, in cases involving a mental impairment, 42 U.S.C. §421(h) requires that the Secretary must make "every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment" prior to denying the claim.

Despite these very clear directives, SSA has changed the rules of play--doctors must only sign the RFC, not fill it out and not read "all the evidence we have." SSA budget cuts are forcing the DDSs to cut back on staff physician time. As a result, the cases per doctor ratios are climbing. Under these circumstances, it is inevitable that physicians faced with mountains of files will resort to simply signing off on the RFC forms as they have already been filled out. They will not take the time to wade through the disabled person's file to determine the accuracy of the RFC decision they are signing. This violates the regulation, the statute, and the basic concept underlying the disability evaluation process that there must be an individualized assessment made in each case.

(ii) SSA is not wholly committed to full implementation of the current mental impairment listings. These regulations expire at the end of three years, in August, 1988. (The statutory provision requiring SSA to issue new listings does not.) One recent SSA issuance suggests that SSA may be looking for ways to modify the criteria. In a request for proposals, SSA indicated its interest in proposals for projects which will "identify those listed mental disorders that can, with appropriate medical treatment, remit to the extent that the beneficiary's ability to work is restored....Evidence should be presented showing that the treatment regimen meets two criteria: that the treatment remediates the disorder and that compliance with the treatment leads to restored ability to work." 52 Federal Register 24098, 24106 (June 26, 1987). Given the recency of development of the current criteria and the expertise of those who developed them, it would appear that SSA's purpose here is to attempt to create evidence to undermine the current criteria.

SSA's lack of commitment to the Listings has become very clear; one result of the pressures and budget cuts is that DDS staff are not taking the time to properly develop the evidentiary record. The problems are very obvious in mental impairment cases and are just beginning to appear in CDR cases. For example, in mental impairment cases:

(a) Daily activities: SSA and the DDSs are making no effort to determine the context of a person's daily activities. This information is critical to the proper application of the mental impairment listings. They do not collect information to assess (1) the sustainability of the activities (for example, can they be done routinely, on an hourly, daily, or weekly basis consistently over time?); (2) whether the person's actions are done independently, without assistance, direction, or special consideration; and (3) whether the person's activities are appropriate to the circumstances and effectively carried out. (For example, if SSA is told the person can cook, they never learn the food is inedible because it is burned. Or, if told the person goes to the grocery store, they never learn if s/he makes appropriate purchases.)

(b) In considering whether a person suffers from repeated episodes of deterioration or decompensation, SSA is not fully documenting the frequency, duration, and effects on functioning of such episodes. In addition, it appears that SSA is taking a very narrow view of the kinds of circumstances which qualify as such an episode. Instead of looking at periods of significant worsening of signs/symptoms, it is looking only at cases involving circumstances such as a hospitalization. This cuts the work but results in artificially optimistic assessments of individuals' capabilities.

(c) SSA is telling DDSs to mark some cases as "no mental impairment" in order to avoid developing the cases, even though the individuals have some mental impairment. There apparently are memos from SSA which tell DDSs that development of mental impairment can be very limited if a cursory review of the person's daily activities suggests the person is not significantly limited. In those cases, it appears that SSA is telling DDSs to record these cases as "no mental impairment." By categorizing cases in this fashion, the DDS then avoids the requirement that the case be reviewed by a psychiatrist or psychologist and that the Psychiatric Review Technique Form ("PRTF") be completed.

A recent report by the SSA Associate Commissioner for Assessment to the Associate Commissioner for Disability provides support for the concern that SSA's current practices are resulting in illegal denials:[5]

> "This evaluation underscores prior findings from QA [Quality Assurance] body system reports that DDS accuracy under the revised listings has deteriorated markedly, particularly among decisions unfavorable to the claimant."

In the accompanying analysis, at page 6, the author states:

> "In FY 1985, about 70 percent of the QA denials returned to the DDS were reversed to allowances. If similar reversal experience applies to the QA mental denials, it would suggest that a large number of DDS mental denials should be allowances." (Emphasis added.)

III. These Problems Are Exacerbated By SSA's Failure To Apply Correct Standards

In addition to flawed evidence development and inadequate and inaccurate RFC determinations, disabled people are being continually injured by SSA's failure to properly implement the statutory and regulatory standards of the program. I have already mentioned some of the problems with the medical improvement standard. There are problems in many other areas. Some examples I will focus on here are: consideration of multiple impairments, pain, evaluation of cardiac cases, and weight to be accorded the treating physician's opinions.

A. Multiple Impairments

Prior to the passage of the 1984 Act, SSA did not consider the combined effect of multiple impairments in evaluating disability. It went so far, in Social Security Ruling 82-55, to state that it would not consider the combined effects of "nonsevere" impairments. In 1984, Congress told SSA to do the obvious: look at the combined effect of multiple impairments. (§4, P.L. 98-460.)

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[5] "Impact of the Revised Listings for Mental Disorders--INFORMATION," Memo from the Associate Commissioner for Assessment to the Associate Commissioner for Disability, March 24, 1987.

After enactment of this provision, SSA took the novel position that §4 reflected a change in the Congress' position on consideration of multiple impairments. The courts have uniformly rejected this approach, instead finding that the 1984 Act simply codified what the Congress and the courts already believed was the policy.[6] Meanwhile, courts have continued to fault SSA for its failure to consider the combined effects of impairments.[7] SSA's behavior in the courts on this issue provides clear evidence of its desire to interpret the provisions of P.L. 98-460 as narrowly as possible, regardless of Congress' intent.

The multiple impairment provision took effect on December 1, 1984. SSA issued "interim final" regulations on March 5, 1985. 50 Federal Register 8726 (March 5, 1985). The regulation basically tracks the statutory language. 20 C.F.R. §404.1523. SSA makes virtually no effort there or in its other issuances to seriously explain to its staff exactly how they are to consider the combined effects of impairments. As a result, there continue to be cases where SSA ignores the combined effect of impairments.

B. Cardiac impairment cases

It is SSA's position that if treadmill test results exist (which it will often pay for in order to secure them), the results of that one test take precedence over the results of all other tests in assessing whether a person's ischemic heart disease is disabling. SSA will not consider the other medical evidence under the Listings or in assessing RFC. This is true despite the requirement that SSA consider *all* evidence. 42 U.S.C. §423(d)(5)(B), §9(b)(1) of P.L. 98-460. "To ignore all medical findings other than the treadmill test results deprives the claimant of the opportunity to prove 'his limitations' not reflected in the latter results." *State of New York v. Bowen*, 655 F. Supp. 136 (S.D. N.Y. 1987). Unfortunately, the order in *State of New York* only applies in that state. Throughout the rest of the country, SSA continues to ignore other evidence, such as angiograms, in determining disability. The result is that some individuals severely disabled by ischemic heart disease are being denied benefits.

C. Treating physicians

Somewhat incredibly, after Congress told SSA in §9(b)(1) of P.L. 98-460 to make "every reasonable effort" to secure evidence from the treating physician, SSA attempted to turn this directive on its head, arguing that this meant that Congress intended to overrule the existing caselaw which states that SSA must give greater weight to the treating physician's opinions.[8] No such rule was explicitly or implicitly intended. If anything, the reverse was true. Senator Levin, one of the co-sponsors of the original version of S.476, the Senate bill which included §9(b)(1), stated, "By passing this legislation today, we are directing SSA to give great credence to the findings and reports of a beneficiary's treating physician...." *Congressional Record*, p. S6231 (May 22, 1984).

While the courts have not agreed with SSA's analysis, much attorney time continues to be devoted to assuring that SSA follows Circuit precedent on this issue. Because claimants must often get to court before the proper rule is applied, SSA's failure to accord proper weight to the treating physician's opinions creates great delays and hardship for disabled claimants. Meanwhile, through proposed rules [see 52 Federal Register 13014 (April 20, 1987)] and a draft ruling, SSA continues to attempt to cut back on the weight accorded the treating physician's report. Recently, in Schisler v. Bowen, CIV-80-572E (W.D. N.Y. August 5, 1987), the district court noted that "There lurks in its [the draft ruling's] lengthy and discursive text bases for not applying the treating physician rule."

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[6] See *Johnson v. Heckler*, 607 F. Supp. 875 (N.D. Ill. 1984), *aff'd.* 769 F.2d 1202 (7th Cir. 1985); *Reichenback v. Heckler*, 808 F.2d 309 (4th Cir. 1985); *Bowen v. Heckler*, 748 F.2d 629 (11th Cir. 1984).

[7] *See, for example*, *Mowery v. Heckler*, 771 F.2d 966 (6th Cir. 1985).

[8] This is only one example of many where SSA and its attorneys sought to thwart the benefits of the 1984 Act through perverse arguments in the courts. Similar problems arose on jurisdictional issues and on the rights of mentally impaired individuals who had cases pending at the time of enactment.

D. Pain

Section 3 of P.L. 98-460 codified a pain definition for the first time. It expired on December 31, 1986. The conferees stated that the statutory standard was only intended to codify SSA's current policy on pain. However, because SSA had no idea what its policy was and because it had already told at least one court that the court's decisions on pain reflected SSA's decisions, see Polaski v. Heckler, 739 F.2d 1320 (8th Cir. 1984) and 751 F.2d 943 (8th Cir. 1984), SSA created further confusion when it proceeded to tell circuit courts all over the U.S. that it had always agreed with the decisions it had previously fought furiously. See, for example, Green v. Schweiker, 749 F.2d 1066 (3d Cir. 1984). The bottom line is that, due to SSA's actions since 1984, there continues to be a great deal of confusion within SSA and the DDSs about the proper standard for evaluating pain. There continues to be persistent disregard of claimants' testimony on the intensity and duration of pain, and failure to consider pain in assessing (1) RFC, (2) the effect of non-exertional limitations, and (3) medical equivalence to a listed impairment.

IV. In Addition To These Problems, The Commissioner Has Designed Other Obstacles To Securing Benefits

A. SSA is cutting back its assistance to disabled people in completing the application and in securing evidence.

SSA has changed the procedure it utilizes when a disabled person wants to apply for benefits. See Chicago Region (V) memo No. 16-87, dated January 28, 1987, entitled "PROGRAMS--Instructions on the Self-Help Completion of Disability Reports at Home and Claimant Involvement in Obtaining Medical Evidence of Record (MER)--ACTION." The memo first notes that "One of Commissioner Hardy's objectives is to deliver the highest level of quality service to the public in the most timely and cost-effective manner."

It then discusses two new SSA initiatives. Pursuant to one initiative, when a disabled person comes into the SSA district office to apply for benefits, SSA staff will give the person the application and send him/her home to fill it out. This applies to other reports as well. According to the memo, "about 20 minutes of interviewing time is saved resulting in an efficient and more pleasant interview."

Also, SSA is now asking claimants to obtain the medical evidence of record (MER), "permitting them to take a more active role in the processing of their disability claims." For many disabled people this "active role" will result in denials for failure to cooperate in securing evidence. It is particularly troubling that SSA lists only three exceptions to the rule of self-help:

(1) Claimants "alleging" mental impairments "such as schizophrenia, paranoia, mental retardation, anxiety, nervousness, etc." are excluded "unless they are accompanied by a representative." (Emphasis added.) It should be noted here that SSA generally defines "representative" to include family and friends. These individuals are often no more adept at form completion than the applicant. In addition, not everyone with a mental impairment alleges that the impairment is the basis for the disability application. Few people walk in and allege they are "paranoid" or "schizophrenic."

(2) "[I]f the claimant requests it, or expresses concern or indicates apprehension about his/her ability to complete the form," the interviewer "should always" complete it. There is no indication that SSA will tell the person that if s/he asks, SSA will help.

(3) "The interviewer should also assist in any other situation such as dire need or homelessness...."

There is no mention of illiteracy and/or inability to speak, read, or write English, or blindness as conditions requiring completion by SSA staff.

While the transmittal does not address it, there is apparently some concern among SSA staff that SSA does not intend to take protective filings when it sends the person home with the application. If it does not, many individuals could lose a month or more of benefits if they file their applications after the end of the calendar month in which they originally came to the office.

B. SSA's new "appointment" system work major hardships on disabled individuals.

In the past, a person could go into the SSA office and apply for benefits. Now, when the person goes in, s/he waits to be seen thinking that s/he will be applying. Instead, s/he is handed the application and sent home to fill it out. S/he is then told to return for an appointment, often weeks away.

It is often very difficult (and expensive) for a disabled person to travel to the SSA office. As has been discussed in greater detail at other recent hearings, the "appointment" process simply frustrates the efforts of a disabled person to file his/her claim with SSA.

C. SSA is moving away from telling disabled applicants and beneficiaries the reasons for its negative decisions.

In July, 1987, the head of the Massachusetts DDS, Kasper M. Goshgarion, testified before a field hearing of the Subcommittee on Administrative Law and Governmental Relations (Judiciary Committee). He stated that the DDS was forced by SSA to "implement specific containment measures." Among those measures is "Elimination of denial rationales effective on December 1, 1986, resulting in decreased transcription costs." On July 28, 1987, Commissioner Hardy described SSA's efforts more obliquely in testimony before the Subcommittee on Human Resources and Intergovernment Relations of the Government Operations Committee. She discussed SSA's efforts to "improv[e] the written rationale process to avoid duplication."

The Social Security Act clearly requires that SSA tell a disabled person the reasons for its decision. 42 U.S.C. §405(b)(1) requires, in part, that any disability decision which is "in whole or in part unfavorable" "shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the Secretary's determination and the reason or reasons upon which it is based...." (Emphasis added.)

In other words, the pressures on the DDSs are so great that, with SSA's blessings, they are breaking the law. Congress added the language in §405(b)(1) in 1980 because it believed people needed to know this information in order to assess whether to appeal.[9] By eliminating rationales (or abbreviating them into virtual non-existence), SSA is significantly complicating the disabled individual's ability to make this crucial assessment.

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[9] The Senate Report stated: "It is felt that the brief form letter which constitutes the notice does not provide the individual who has been denied benefits with enough of the particulars of his case to provide assurance that his case has been fairly decided." The report stated that inclusion of the reasons "will add a number of positive factors to the adjudication process. (Footnote continued on next page.)

V. All Of These Problems Simply Add To The Complexity Of The Disability Evaluation Process And Exacerbate Further The Need For Attorney Representation

It seems highly consistent that while SSA continues to create obstacles to prevent eligible disabled people from receiving benefits, it also continues to develop creative ways to discourage attorneys from representing disabled people. After all, what good is it to have all these obstacles if a disabled person can still get an attorney to assist him/her in wending his/her way through the process and may ultimately prevail?

Earlier this year this Subcommittee acted to correct the attorneys fee problems in the OASDI program. The Subcommittee's actions have the widespread support of organizations representing elderly and disabled people as well as the private bar. Despite, or perhaps in spite of, the Subcommittee's actions, Associate Commissioner Eileen Bradley is currently circulating a draft proposed regulation which, if issued, would assure that no private attorney would ever appear before SSA. The proposal establishes incredibly complex, highly arbitrary, formulae for determining fees.

Curiously, the thrust of the draft, over-regulation, is contrary to both Deputy Commissioner Lou Enoff's statements to members of the Subcommittee at the mark-up on the attorneys fees provision and, is contrary to the general theme of this Administration. While there is no question that there is a role for SSA in the attorneys fees context, it is the one designed by this Subcommittee. We therefore urge the Subcommittee to recommend to Secretary Bowen that (1) no further action be taken on the draft and (2) SSA be instructed to return to the pre-March 31, 1987 rules for payment of attorneys fees at least until the final fate of the provisions in the Ways and Means Budget Reconciliation package has been resolved.

Conclusion

While it would be wonderful if SSA had simply properly implemented the 1984 Act, that has not been the case. It is apparently unrealistic to expect that those who terminated the benefits of almost 500,000 people and resisted the reform legislation would then embrace it and fully implement it. It is critical that the Subcommittee closely monitor SSA's policies and practices to determine what additional action will be needed to assure that eligible individuals receive the benefits to which they are entitled.

Thank you.[10]

The State agency decision will be on a sounder base because the examiner will be required to formulate the reasons for his decision in written form and the claimant may be less likely to appeal the decision if he understands how the law relates to his particular case." S. Rpt. No. 96-408, 1980 U.S. Code Cong. & Admin. News 1277, 1334-5.

[10] Copies of documents referred to in this statement have been submitted to the Subcommittee.

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DOCUMENTS ACCOMPANYING THE TESTIMONY OF EILEEN P.SWEENEY

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Thomas W. Hayes
Auditor General

February 19, 1987 I-717

Honorable Art Agnos, Chairman
Members, Joint Legislative
  Audit Committee
State Capitol, Room 3151
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning an investigation of the Disability Evaluation Division of the Department of Social Services. Staff of the division have been interfering with the sampling procedures used to randomly select cases for quality assurance review by the Social Security Administration. Staff made substitutions in samples when they found cases with performance errors. As a result, the number of errors that the division makes in determining the medical eligibility of California residents for disability benefits is understated. Branch officials within the division were aware of and condoned the practice of substitution.

Respectfully submitted,

Thomas W. Hayes

THOMAS W. HAYES
Auditor General

THE AUDITOR GENERAL'S
REPORT OF INVESTIGATION I-5008

ALLEGATION

An official of the Disability Evaluation Division, (division) Department of Social Services (department) has illegally instructed division personnel to screen all cases submitted to the Social Security Administration for review. The division substitutes up to 80 percent of the cases in randomly selected samples with cases that have been carefully screened for errors. As a result, the Social Security Administration, which is responsible for evaluating the performance of the department, is receiving and using unrepresentative data to assess the accuracy of state-processed disability cases.

RESULTS OF INVESTIGATION

Our investigation substantiated the allegation. We found that at five of the six branch offices, professional staff screen cases included in the random sample and make substitutions when they find cases with errors. We found no evidence that the division official instructed personnel to screen the cases. We did find that branch officials have been aware of and have condoned the substitution practice. The cases included in the samples are reviewed by the disability quality branch of the Social Security Administration to assess the performance of the department in administering the disability program. Therefore, the Social Security Administration is developing and using performance measures of the State's disability program from an unrepresentative sample of cases. As a result, performance measures do not accurately reflect program performance. We can conclude that the measures used to ensure quality are inflated; however systemic weaknesses in the sampling procedures make it impossible to determine the frequency of substitution or the degree of inflation.

Background

Under an agreement with the federal government, the department's disability evaluation program determines the medical eligibility of California residents for benefits under Title XVI (Supplemental Security Income) and Title II (Disability Insurance). The Social Security Administration provides program standards, leadership, and oversight. The department is responsible for providing and maintaining an effective system for processing the claims of those who apply for benefits under the program. To ensure effective and uniform administration of disability programs throughout the United States, federal regulations specify two performance standards for the state-administered programs--one for performance accuracy and one for processing time. To evaluate the performance accuracy, the disability quality branch of the Social Security Administration reviews a random sample of cases from each state and computes a performance accuracy rating. States that consistently fail to meet the minimum performance standards may receive mandatory technical and management assistance from the federal government. If, after a period of assistance, a state continues to fail to meet minimum performance standards, the federal government may find the state in substantial failure and may ultimately take over the disability function.

Case Substitution

Our review of sampling procedures at the six branch offices disclosed that the following five branches are substituting cases selected for the random samples: Fresno, Los Angeles East, Los Angeles West, Oakland and San Diego. Clerical staff of these branches assemble completed cases and pull samples at designated intervals. Professional staff then review the cases in the sample before forwarding it to the Social Security Administration's disability quality branch for its review. At the five branches named, the reviewers substitute cases with no performance errors for those with performance errors. The branch staff we interviewed estimated the following substitution rates:

Fresno branch: between 20 and 40 percent
Los Angeles East branch: 40 percent
Los Angeles West branch: less than 1 percent
Oakland branch: 5 percent
San Diego branch: between 10 and 12 percent.

The branches vary in the circumstances that they consider justification for substituting cases. Los Angeles West, the branch reporting the lowest substitution rate, substituted cases whenever failure to correct a decisional error at the branch level might prolong determination for an especially needy claimant. The branches with the highest substitution rate substituted cases whenever a performance error appeared possible.

All but one of the five branches initiated the practice of substituting sample cases within the last 18 months. The fifth branch, Los Angeles West, has had for several years a policy for making substitutions under specific circumstances. Officials in all five branches were aware of the practice and condoned it; in fact, most of the officials assumed responsibility for initiating the practice. However, one branch official indicated that an official from the division headquarters had given instructions to review and substitute cases targeted for the samples. We were unable to corroborate that statement or to uncover any consistent patterns in the circumstances that precipitated the practice of substitution.

We cannot determine the degree to which the practice of substitution has affected the performance ratings for state and branch offices. We can conclude, however, that the ratings are inflated. The minimum performance standard mandated by federal regulation is a rating of 90.6 percent, meaning that in 90.6 percent of the cases reviewed, two performance standards are met: 1) the decisions are correct and 2) case files contain the documentation needed to justify the decisions. In the past two years, the Social Security Administration's monthly, statewide ratings for California have never been at or below the 90.6 percent level. However, during the same time, in four of the six branches, monthly ratings have been at or below that level 22 times. If the ratings at all branches had been accurate, the overall state rating could have fallen below the minimum performance level.

Systemic Weaknesses in Sampling Procedures

The major factor contributing to the practice of case substitution was the absence of internal controls at two points in the sampling procedures. First, when staff at the branch offices placed closed cases in the population of cases to be sampled, they did not number the cases. Without a sequential numbering system, it is impossible to ensure that cases are pulled at the proper intervals. Second, when staff pulled the cases to be included in the quality assurance sample, they maintained no record of the specific cases pulled for the sample. Thus, it is not possible to verify that the cases pulled are, in fact, the cases forwarded to the Social Security Administration for review. Because of these weaknesses, the substitution rates estimated by the branches cannot be verified or evaluated.

During our investigation, the Disability Evaluation Division implemented an automated sampling system that should correct the weaknesses stemming from the lack of controls. The new system should eliminate the opportunity to interfere with proper random sampling procedures and should help to assure that performance measures for California are accurate.

Other Factors Contributing to the Practice of Case Substitution

Three other factors contribute to the practice of case substitution: a competitive environment in the disability program; the branch staff's lack of regard for the performance measures; and low incentive for management to uncover improper practices that inflate performance ratings.

The disability program is characterized by a strong sense of competition. The Social Security Administration computes and publishes monthly performance ratings for each region, state, and branch. Officials of each region, state and branch know their rank compared with that of their counterparts. Officials of branches with low ratings, embarrassed by their rank, want a more favorable position in the public ratings; those with high ratings wish to maintain their positions. As a state, California has, until recently, ranked in the lower half of the ratings compared to all other states. In the last five months of 1985, California's performance ratings improved to such a degree that its rank rose to among the top ten states in the country. We do not attribute this improvement solely to substitution of cases, although we believe this practice played some role in California's improved performance ratings. Other factors, such as management priorities and intensive case reviews, may have also contributed to the increase in ratings for California.

A second factor in case substitution is the branch staff's lack of regard for the performance rating that measures two components of performance--the accuracy of decisions and the thoroughness of documentation to support decisions. The former measures whether the decision made was a correct one. The latter measures whether the documentation compiled to justify the decision was complete and correct. The branches traditionally are rated very high on the correctness of their decisions; however, they earn lower ratings for providing proper documentation. The lower rating for providing proper documentation results in a lower overall performance rating. In the opinion of branch staff we interviewed, the combined performance rating devalues the most important issue, whether decisions are correct. Because staff do not value the combined rating, they do not consider interference with sampling procedures to be a major problem when placed in the context of their primary task--correctly determining applicants' eligibility within reasonable timeframes.

A third factor contributing to case substitution is management's lack of incentive to uncover improper practices that inflate performance ratings. Staff and management at the branch, state, and federal levels all benefit from high performance ratings that reflect favorably on the disability analysts and on overall program management. Both the department and the regional office of the Social Security Administration received the letter that prompted our investigation of this complaint. After conducting cursory investigations, the division official and an official of the Social Security Administration concluded that there was no substance to the complaint. In addition, in the six months preceding their investigations of the complaint, the Social Security Administration disability quality branch issued two reports suggesting that the samples it received from three California branches were not random samples. Despite the complaint and the reports, after only a brief investigation into the matter, both officials were satisfied with their conclusions that the complaint had no substance. Since they were familiar with the reports that raised concerns about the samples, we question the thoroughness of their investigations that disclosed no improprieties in sampling procedures.

Conclusion

Staff of the Disability Evaluation Division of the Department of Social Services have been interfering with the sampling procedures used to randomly select cases for quality assurance review by the Social Security Administration. In five of the six branches, staff made substitutions in samples when they found cases with performance errors. Estimated substitution rates range from less than one percent to 40 percent. As a result, the Social Security Administration has been developing performance measures from unrepresentative samples, and its measures of quality assurance do not accurately reflect the performance of the department's Disability Evaluation Division. Branch officials within the division were aware of and condoned the practice of substitution. Because of systemic weaknesses in the sampling procedures, we could not determine what the actual rate of substitution was and how it influenced the performance ratings for the State and the branch offices. The Disability Evaluation Division has implemented an automated sampling system that should correct the systemic weaknesses in sampling procedures.

AGENCY RESPONSE

According to the director of the Department of Social Services, the five branch officials involved in the sample tampering will be demoted and each will receive salary reductions amounting to over $1,000 per month. The official at division headquarters will be relieved of his duties and demoted to a lower level position. In addition, the department will assess the division's current operation and formulate recommendations for improving and maintaining high employee morale and job satisfaction. The department will also review the division's automated sampling system to verify the system's integrity. Finally, the department will contact the Social Security Administration to obtain information regarding strategies and procedures developed by the most successful jurisdictions and to discuss the competitive nature of the program and the effect it may have on employee behavior and performance.

Note: The Branch Chief from Sacramento was also envolved in the sample tampering and has also been demoted. Thus, to date, the Deputy Director and six out of six Branch Chiefs have been demoted.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
Chicago Regional Office

REGIONAL MEMORANDUM NO. 16-87 DI-7

TO : All District, Branch, Teleservice Center, and Satellite Office Managers

DATE: January 28, 1987

Refer to: SD5B4

FROM : Office of the Regional Commissioner

SUBJECT: PROGRAMS--Instructions on the Self-Help Completion of Disability Reports at Home and Claimant Involvement in Obtaining Medical Evidence of Record (MER)--ACTION

INTRODUCTION

One of Commissioner Hardy's objectives is to deliver the highest level of quality service to the public in the most timely and cost-effective manner. To that end we have developed two initiatives: Field Offices Requesting Medical Evidence of Record (FORMER) and increasing claimant participation in the interview process.

Under FORMER the MER is requested at the earliest possible time --immediately following the FO interview. Each state's Quality Circuits Steering Committee has submitted a FORMER proposal to the Regional Office. We are now reviewing those plans.

The second initiative (instructions attached) focuses on claimant completion of disability reports at home for teleclaims, appointments, and, on an optional basis, for walk-in interviews. This process minimizes the FO time in completing forms and permit claims representatives (CR's) to focus on supplementing claimant responses. Procedures are also included for claimants to obtain MER from their treating sources. These procedures should be implemented as soon as possible.

BACKGROUND

The Atlanta Region piloted claimant completion of disability reports at home and concluded:

- Claimants are able to provide a picture of themselves in their own words so that the DDS' have a better understanding of the condition and how it prevents them from working;

- About 20 minutes of interviewing time is saved resulting in an efficient and more pleasant interview; and

- Accuracy of the disability report is enhanced, not diminished, because there is active management review of the process.

Additionally, claimants are asked to obtain MER from their treating sources at the same time, permitting them to take a more active role in the processing of their disability claims.

MANAGEMENT RESPONSIBILITIES

The success of these initiatives depends on careful management attention. Ongoing supervisory reviews of the disability reports are necessary to ensure an accurate and timely disability product. Reviews of interviewing practices are also necessary to ensure the interviewer exercises correct judgement.

I know I can count on your commitment to these initiatives. I will appreciate your feedback regarding these new procedures and any recommendations you have to improve the process.

Any questions or comments concerning this memorandum or the attachment should be directed to Ilene Kirtzic of the Disability Programs Branch at commercial (312) 886-3418 or FTS 886-3418.

Marlene M Moleski

Marlene M. Moleski
Regional Commissioner

Attachment

REGIONAL TRANSMITTAL NO.

Audience: CR, DRT, FR,
OA, OS, RR,
DDS--REF
Chicago Region

Originating Office: P-DPB

PROGRAM OPERATIONS MANUAL SYSTEM
Part 04 - Disability Insurance
Chapter 110 - Initial Claims Processing

New Material	No. of Pages
DI R11005.020..........	3

ACTION NOTE

Cross-refer DI 11005.020 to DI R11005.020

Background

Field offices (FO's) are responsible for ensuring that the SSA-3368-F8, SSA-3820-F6, SSA-3441-F6 and SSA-3369-F6 Disability Reports contain complete and accurate information. These forms were designed for self-help and most claimants and/or their representatives usually have little or no difficulty in completing them.

Explanation of Manual Supplement

This supplement expands self-help procedures to allow claimants and/or their representatives to complete these forms at home in disability teleclaims, appointment situations, and on an optional basis for walk-in interviews.

U.S. DHHS
Social Security Administration
Chicago Regional Office

Effective Date: Upon Receipt

R11005.020 Self-Help: Completion of Disability Reports at Home

A. Background

The FO's are responsible for ensuring that the SSA-3368-F8, SSA-3820-F6, SSA-3441-F6, and SSA-3369-F6 Disability Reports contain complete and accurate information. These forms are designed for self-help and most claimants and/or their representatives usually have little or no difficulty completing them.

Self-help has been used successfully in most FO reception areas and provides several advantages:

- Valuable interview time is saved resulting in increased efficiency;
- Claimants can use their own words to present a better picture of their disability so that adjudicators better understand their condition and how it prevents them from working; and
- Part of the self-help procedure provides claimants the opportunity to secure medical evidence of record from their treating sources and to submit it with the disability reports.

B. The New Self-Help and Medical Evidence Procedure

The new self-help procedure allows claimants to complete the disability reports at home in disability teleclaims, appointment situations, and for walk-in interviews on an optional basis. This procedure applies to both initial and reconsideration claims.

These new guidelines do not replace regular claims taking policies. Claims should always be taken if the claimant wishes to file or there is apparent eligibility.

This procedure permits claimants to access medical, employment, and other records and should result in a better disability product and improved public service.

1. Walk-In Interviews (OPTIONAL)

   The interviewer must carefully:

   - Assess the claimant's ability to complete the form at home. If it is doubtful, see "Exceptions."
   - After ensuring that the claimant meets all the nondisability entitlement factors, complete all nondisability forms, obtain signed medical releases, record complete observations and provide reporting instructions.

- Complete the claimant's name, SSN, and telephone number on the form. Show a unit designation for mail association.

- Have the claimant complete the signature block on the report to avoid unsigned forms.

Explain the self-help procedure and give the claimant the form to take home for completion and include a prepaid postage return envelope with a unit designation. Stress the importance of thorough and timely completion of the form. Explain that the claim cannot be processed until the report is received.

Request that the claimant submit any medical evidence he/she has obtained from a medical source. An SSA-12 (GN 00202.125C.) should be used as a guide, and highlight the items the claimant should obtain and submit. If the claimant will be seeing his/her attending physician within 5 calendar days of the interview, he/she should be asked to, if possible, obtain and submit medical reports along with the disability forms.

- Emphasize the timely return of the form and followup by telephone if it is not received within the predetermined timeframes established by each office, e.g. 5 days.

- Use the tally for control purposes.

- Carefully review the form upon receipt.

- Telephone the claimant to obtain missing or incomplete information or to clarify any discrepancies. Use a Report of Contact to document any changes (DI 11005.050).

2. Teleclaims Interviews

- Except for having the claimant sign the Disability Report at the interview, all the steps in DI R11005.020 B.1. (above) should be followed.

- The forms will be mailed to the claimant for completion.

- The signature blocks should be highlighted and the claimant must be advised to sign all forms after completion.

- Record pertinent observations about difficulty in speaking, coherency, hearing, understanding, and answering (DI 11005.045).

- Tightly control teleclaims via the tally or other FO device.

3. Appointments

- The items in DI R11005.020 B.1. (above) also apply where appropriate.

- When the appointment is scheduled, the disability report should be mailed to the claimant for completion whenever possible and brought to the FO at the time of the scheduled appointment. The person scheduling the appointment should use the SSA-12 as a guide in advising the claimant what documents to bring to the interview. This includes requesting the claimant to submit medical reports in his/her possession. If the claimant will be seeing his/her treating source before the scheduled appointment, ask them to obtain a medical report from that source and bring it to the interview. If there is sufficient time, the standard teleclaims forms should be mailed to the claimant for completion prior to the interview. The SSA-12 should be enclosed with these forms as a guide.

- The interviewer must carefully review all forms and record observations during the interview.

C. Exceptions

The following exceptions apply:

- Any claimants alleging a mental impairment such as schizophrenia, paranoia, mental retardation, anxiety, nervousness, etc., are excluded from this procedure, unless they are accompanied by a representative. These claimants usually need assistance in completing forms and obtaining evidence.

- The interviewer should always complete the form if the claimant requests it, or expresses concern or indicates apprehension about his/her ability to complete the form.

- The interviewer should also assist in any other situation such as dire need or homelessness where it is possible the form will not be properly completed or returned timely.

D. Conclusion

Both management and staff attention are essential to ensure the success of this procedure. Ongoing supervisory review and good claims representative (CR) judgement are necessary to ensure a complete and accurate product.

Use of these procedures should make more productive use of CR time and in many cases improve the information going to the DDS'.

Quality Circuits can be used to resolve any problems that may occur.

EXHIBIT II

TESTIMONY OF
KASPER M. GOSHGARIAN, DEPUTY COMMISSIONER

TO

THE SUBCOMMITTEE ON ADMINISTRATIVE LAW AND GOVERNMENTAL RELATIONS
OF THE HOUSE OF REPRESENTATIVES

AT

A HEARING TO ASSURE CORRECT ADMINISTRATIVE PROCEDURES
TO SOCIAL SECURITY DISABILITY CLAIMANTS

ON

MONDAY, JULY 20, 1987
IN PROVIDENCE, RHODE ISLAND

KMG:1268M

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TESTIMONY OF KASPER M. GOSHGARIAN, DEPUTY COMMISSIONER
TO
THE SUBCOMMITTEE ON ADMINISTRATIVE LAW AND GOVERNMENTAL RELATIONS
ON JULY 20, 1987
IN PROVIDENCE, RHODE ISLAND

A. INTRODUCTION

I would like to take this opportunity to thank Chairman Barney Frank and the members of the Subcommittee on Administrative Law and Governmental Relations for this opportunity to provide testimony regarding the budget and staffing restrictions affecting the management of the disability program in the Commonwealth of Massachusetts. As you may be already aware, the Commonwealth of Massachusetts has had a keen interest in the proper management of the disability program for several years. Our disability determination program experienced significant public scrutiny beginning in 1981. We remember the horror stories and media attention regarding disabled individuals who were terminated from the rolls not because they medically improved, but rather because the ground rules for eligibility had changed. And, we had little defense since we were administering the program in full compliance with existing SSA regulations, policies and procedures. The disability program at that time had no positive constituency. The organization was suffering, program beneficiaries were suffering, our employees were demoralized, and the integrity of the program was jeopardized.

Within the Commonwealth, it became clear that action was necessary. It was important for us to first listen and understand the magnitude of the problem. We listened to our constituency, including disabled individuals, legal and private advocates working on their behalf, state legislators, congressional staffers and others who had experience and understanding regarding the policy and practice problems. It became imminently clear that change was necessary to correct the systemic policy problems affecting severely disabled individuals. As such, within the Commonwealth, we developed a medical improvement standard based on First Circuit Court of Appeals case law. We also improved our internal procedures and practices. We provided input to our Congressional Delegation regarding national policy. We worked with state legislators, other DDS's and the Social Security Administration. As a result of our efforts, those of our constituency, and those of other states, the 1984 Disability Benefits Reform Act was enacted by Congress. It's enactment was a tribute to the hard work of scores of individuals in Massachusetts, hundreds of individuals nationally, and most importantly, the commitment of Congress to assure fair and equitable service on behalf of the disabled citizens of this nation.

It was our anticipation that with the enactment of new legislation and appropriate regulations, the disability program would operate under an atmosphere of stability and national consistency. We also anticipated regaining the public confidence that had eroded as a result of the CDR crisis. It was our judgment that the Reform Act soundly addressed the policy issues and rendered a program that was comprehensive in documentation, review and decision making requirements.

Unfortunately, what we had anticipated did not become reality. Although comprehensive legislation was enacted and regulations were developed, we have not been provided with adequate resources to comply with Congressional intent. Indeed, we are in a crisis once again and its effects are slowly but surely becoming evident to our constituency. Inadequate resources are just as harmful to disabled applicants as inadequate policy. The net effect is incorrect decisions based on an inadequate data base. It is for this reason that I am providing testimony before you today.

B. DDS ACCOMPLISHMENTS

The DDS in Massachusetts has indeed become a well managed public service organization since 1982. Our accomplishments are as follows:

1. More intensive developmental practices have resulted in a marked improvement in overall allowance rate from 28% in FY'83 to approximately 50% at present.

2. The implementation of a Community Affairs function to provide liaison with Congressional staff, legislators and advocates.

3. The implementation of a Homeless Project to assure that homeless individuals are afforded their full legal and ethical rights for disability evaluation.

4. The implementation of an AIDS liaison function to assure the most timely processing of cases for individuals with AIDS and ARC.

5. The implementation of a most successful DDS Advisory Committee made up of disabled individuals, legal and other advocates, and service providers. This group provides timely input on internal practices. Additionally, committee members assist in the training of staff in terms of specific disability issues.

6. The implementation of special procedures for the evaluation of traumatically head injured individuals.

7. The prioritizing of CDR decision review cases to assure timely response for this population which have been awaiting a re-review since 1984. The DDS has completed its initial review in over 1800 decision review cases.

8. The processing of all held mental impairment and Code 122 cases utilizing the new mental impairment listings and standards.

9. The implementation of the new mental impairment listings and procedures resulting in a marked increase in the mental impairment allowance rate.

10. The implementation of a model medical relations function that provides physician/treating source education and remediation. The Medical Relations Department has implemented statewide, medical education conferences for physicians and hospital medical records personnel.

11. The implementation of fully automated case processing and quality assurance tracking system.

12. The implementation of decentralization with the opening of our Worcester office to provide increased accessibility to claimants in Western Massachusetts.

All of the above accomplishments have included the constructive and thoughtful input of our constituency. In 1982, our relationship with our constituency was adversarial. Today, we work as partners committed to the humane application of comprehensive legislation and regulations as contained in the 1984 Disability Benefits Reform Act. The results of our mutual work has been better decisions, decreased advocacy case complaints, and a decreased number of individuals requesting hearings at the Administrative Law Judge level.

C. FUNDING AND STAFFING OBSTACLES

Since the second quarter of FY'86, the DDS has witnessed a marked change in direction and emphasis by SSA in the implementation of the disability program. In FY'86, the clear message at the beginning of the year was quality. Then Associate Commissioner Patricia Owens stated that we could not afford to make mistakes. The goal was to implement this comprehensive program with all necessary resources to restore public confidence. We had all promised the public that we had entered a new era. Quality was to be job one. Beginning in FY'87, however, the direction set by SSA changed drastically. The emphasis was and remains on production. Our goal was no longer quality but rather increased production per work year (PPWY). It made little difference that the PPWY measurement was flawed and did not provide a meaningful national comparative statistic. In fact, SSA began categorizing states as "good" or "bad" based solely on PPWY outcomes.

The effects of this production emphasis becomes more dramatic as one examines the DDS's operational budget for FY'86 and FY'87. It must be further noted that the FY'87 budget and staffing allocations were revised downward at least three times since August 1986. For comparative analysis, the following data is provided:

	FY'86	FY'87 SSA PROPOSED	DIFFERENCE (%)
CASES:	42,237	47,430	+12%
STAFFING (FTE's):	354	296 (288 + 8 DHU Staff)	-19%
FUNDING:	$20,648,836	$19,167,000	- 7% (12% including inflation)

Thus, SSA is presently expecting the DDS to make determinations on an increased workload with 19% less approved FTE's and less fiscal resources. It should be evident that any productivity improvements, including work simplification initiatives, cannot make up the deficit that had been imposed. In actuality, our fiscal resources are even less if one factors in the effects of inflation and mandatory contractual salary increases.

The SSA approved funding for the first quarter (Oct. 1 - Dec. 31, 1986) was $4,910,109. As the DDS analyzed its obligations on a weekly basis, it became apparent that we were facing a $200,000 shortfall for the first quarter along with an anticipated shortfall of $1.5 million for the entire fiscal year. We requested additional funds from the SSA Regional Office to remain operational during the first quarter. Our request was not approved and no additional funds were made available.

Therefore, the DDS was forced to implement specific cost containment measures in addition to several cost saving initiatives that had already been implemented. Our cost containment measures for remaining operational during the first quarter were as follows:

1. Reduction of total in-house physician hours from 1300 per week to 1100 per week. (This directly and adversely impacts the protocols for thorough medical review that are previously explained.)
2. Reduced cost for CE's per case from $230 to $200.
3. Decreased temporary contract employees by 10 full time equivalent positions.
4. Elimination of denial rationales effective on December 1, 1986, resulting in decreased transcription costs.
5. Enforcement of strict CE protocol compliance intended to decrease CE rate from 34% to 30%.
6. An in-house physician furlough during the Christmas holiday week (estimated cost savings: $60,000).
7. Reduction in CE scheduling in December (estimated cost savings: $140,000).

These actions have long terms effects on the organization and the claimants it serves as follows:

1. Delays in the processing of claims for individuals having pending cases since needed CE's were delayed for at least two weeks.
2. Cases ready for determination not being signed out as a result of the entire medical staff being furloughed.
3. Medical follow-up calls not being made by physicians during the furlough period resulted in further case processing delays.
4. Poor examiner morale due to an increase in caseload size and caseload management issues resulting from the CE moratorium and the physician furlough.

5. Prior to the December physician furlough and reduction in medical examination scheduling, the DDS had markedly improved productivity. However, due to the backlogs associated with the physician furlough, our productivity after January 1, 1987 dropped significantly until organizational stability was regained.

In the third quarter, the DDS faced the same problem. Analysis of obligations indicated a projected shortfall of $200,000 for the third quarter. Once again, we requested financial relief through the SSA Regional Office but were denied. As such, additional cost containment measures were implemented as follows:

1. Further reduction in physician hours to 900 hours per week.

2. Further reduction in consultative examinations (CE's) by 25%.

3. Further reduction of temporary contract clerical employees by five (5) positions.

Even with the aforementioned actions, the DDS projects the use of fourth quarter allocations to supplement the third quarter deficit.

The effects of the third quarter reductions appear evident. We will further reduce physician review of medical information, thus potentially resulting in inaccurate medical decisions. We will further reduce our capacity to make doctor-to-doctor phone calls to resolve medical information conflicts. Finally, decisions will be delayed due to our further reduction in needed consultative examinations.

Current analysis indicates that the DDS will once again be in a deficit situation at the end of the fourth quarter. Since it is fully anticipated that SSA will be unwilling to provide additional funding, further cuts with an associated deterioration in service will be necessary.

D. DETERIORATION IN THE DOCUMENTATION OF MENTAL IMPAIRMENT CASES

As stated earlier, the emphasis in FY'86 was quality. A notable example was the implementation of the new mental impairment listings and procedures. In FY'86, Social Security sent a team to each region to provide instruction regarding the new, comprehensive procedures. The slogan used at these training sessions was "leave no stone unturned". We were instructed to fully develop all allegations, obtain activities of daily living information, contact family members and other significant individuals for functional information and call all employers. The DDS's were instructed to hire additional physicians due to the comprehensive nature of these cases.

As DDS's gained experience with the new procedures, it became clear that mental impairment cases took significantly more time to complete. Most DDS's concluded that it took twice as long to complete a mental impairment case.

As this information was shared with SSA, they decided to change the procedures rather than providing the resources necessary. Since 1986, SSA has embarked on several course revisions that have compromised the intent of the 1984 Reform Act. The first change was to eliminate the narrative summary requirement on the physician review form (PRTF). Next, we were instructed to not make family and/or employer calls unless absolutely necessary to resolve conflict. Then we were instructed to use the incomplete activity of daily living reports obtained by SSA's field office staff. Finally, were were instructed to develop mental impairment secondary allegations only if the symptoms were above and beyond what would be normally expected in conjunction with a physical impairment.

All of the aforementioned SSA course revisions have reduced the time required to determine a mental impairment case. However, the final product is significantly different than the original instructions of 1986. The mental impairment decisions are now based on a less comprehensive data base with decreased physician analysis. The changes have resulted in a decreased mental impairment allowance rate nationally and may not be reflective of Congressional intent.

Finally, where once we were instructed to hire additional psychiatrists, today the Massachusetts DDS must terminate at least six (6) psychiatrists as a means of further decreasing overall costs.

E. FUNDING AND STAFFING ISSUES AS THEY RELATE TO CDR CASE DETERMINATIONS

The original crisis of the disability program commenced with the CDR population. The 1984 Disability Benefits Reform Act instituted a comprehensive medical improvement review procedure. However, the lack of necessary budgetary and fiscal resources have rendered full implementation impossible. The Massachusetts DDS presently has three (3) out of its nineteen (19) case processing units committed to CDR case processing. We have demonstrated excellent accuracy in completing this workload. Yet, we cannot meet SSA's workload demands. Already we have a CDR backlog of 1400 cases. These individuals have all been interviewed by SSA field offices and are awaiting a decision. Some are anxious and assume something is wrong since it is taking so much time to receive a final decision. Clearly, the system is unfair in providing already vulnerable individuals with added suspense and anxiety.

In addition, the lack of resources necessary to conduct CDR reviews is unfair both to the beneficiaries and taxpayers. The marked delays are already creating a population which is disabled as a function of time on the rolls rather than a medical condition. Even if an individual has improved medically, what is his/her prospects for employment if already on the rolls for many years? The lack of resources to complete this workload is unfair to the beneficiary if he/she has medically improved since time on the rolls will affect potential successful employment, and to the taxpayers who must continue to support benefit payments to individuals who have improved and are no longer eligible.

F. EFFECTS OF SSA's IMPOSED HIRING FREEZE

For approximately the last fifteen (15) months, the Massachusetts DDS has been under a complete hiring freeze due to SSA imposed staffing limitations. Unfortunately, however, attrition within a large organization does not occur in all employment categories. As such, the DDS has lost key accounting, data entry, fiscal and clerical positions. After several formal requests, we have been unable to fill any of these key positions.

The effects of this complete hiring freeze has markedly compromised our ability to manage this program. One notable example is our Fiscal Department. The loss of a key accounting position has meant this function is now handled by a less skilled clerical employee. Additionally, our automated fiscal management system has experienced a marked loss in efficiency since several data entry operators have exited the department. These important functions are presently handled by unreliable contract temporary clerical employees and under-trained clerical staff. SSA still requires the timely submission of key accounting and fiscal reports. Yet, the agency does not have the needed personnel to provide such reports. Additionally, the long term effect will be key vendors not receiving timely payments. This will translate into losing important consultative examination panelists and a lack of response to our requests for medical information from community treating physicians. In turn, this will result in increased processing time for case determinations.

The lack of well trained clerical employees has also negatively affected case processing activities. Case examiners have been forced to assume most clerical functions at the unit level. Examiners must now make all follow-up calls to treating sources. In addition, some are completing their own typing of forms. Clearly, this is not cost effective and does not make the maximum use of our examiners' skills. Additionally, it is demoralizing to the staff who no longer view themselves as professionals since they must assume many clerical functions.

In summary, the SSA imposed hiring freeze has negatively affected our productivity and ability to manage this program. The DDS cannot assume full fiscal management accountability without the resources necessary to manage fiscal and administrative operations. Additionally, the use of well trained examiner employees for clerical task completion is not cost effective. It demoralizes staff and negatively affects job satisfaction. Increased productivity must address the hygiene factors of employment.

G. NON-EXISTENCE OF A BUDGET NEGOTIATION PROCESS

The DDS expends a significant number of manhours in the development and submission of budget planning documents. We provide SSA with an annual budget request and comprehensive quarterly spend plans. These documents provide information regarding our budgetary needs and an explanation of what will occur if requested fiscal resources are not made available.

Although significant effort is placed on the generation of fiscal planning documents, no subsequent feedback is received. We are not afforded an opportunity to negotiate key budget items. Instead, we receive a quarterly allocation that bears little or no resemblance to our well documented requests.

Thus, the submission of budget planning information is an exercise rather than a negotiated process. The input of DDS appears to be largely ignored. We never receive an annual allocation and cannot predict the amount of each quarterly allocation. We are asked to manage this program, yet we are never fully aware of the budgetary parameters necessary for effective management.

H. IMPACT OF SSA's IMPOSED LINE ITEM CONTROL

To further complicate matters, in FY'87 SSA assumed full line item control. Not only do we receive an unpredictable quarterly allocation, but in addition, SSA has imposed full line item control in the personnel and medical cost line items. If the DDS is able to realize cost savings in the medical line item through increased outreach to treating sources, it cannot utilize such savings to support the remainder of the program. Rather, it must revert such savings back to SSA. As such, there is little incentive for creativity and overall cost savings.

Clearly, the DDS's must have full line item control to effectively manage this complex program. Constraints already exist since the DDS is not provided with a timely annual budget. When this constraint is combined with SSA's imposed line item control, our ability to effectively manage is severely compromised. SSA not only controls total costs, but additionally imposes staffing ceilings and medical cost ceilings. This renders the budgeting process as meaningless since the DDS may not be able to expend its allocation due to line item constraints. More importantly, however, not expending a budget allocation can lead to a decreased level of service delivery. By example, the decision to purchase a medical examination must be based on need rather than available budgetary resources. Should the DDS be placed in a position of rendering a decision based on less than complete information due to line item restrictions? This question must be considered rhetoric. Otherwise, the continued viability of the disability program is in jeopardy.

I. SSA's PRODUCTIVITY GUIDELINES

Although SSA has been informed by most states that the production per work year (PPWY) index is flawed, it continues to be the key measurement index utilized by SSA. In a survey of DDS's conducted by the Council of State Administrators of Vocational Rehabilitation (CSAVR), 71% of the states responding indicated that PPWY was an unrealistic measure of productivity. One basic reason for this was the variance in organizational structure of DDS's nationally. PPWY includes only those employees who are directly charged to the DDS payroll and counted in the full time equivalent (FTE) calculations. In many states, key departments are not charged to the DDS staffing but rather handled through the indirect cost mechanism. Such services are handled by the parent agency. Examples are as follows:

- Personnel
- Fiscal/Administration
- Mail Services
- Computer Services
- Word Processing

Confirmation of this fact is provided in the variance in indirect cost rates. In the 1986 CSAVR survey, the breakdown of states responding regarding indirect cost rates were as follows:

Range	
0 through 5%	22%
5.1% through 10%	30%
10.1% through 15%	24%
15.1% through 20%	15%
20.1% or greater	11%

The variation in indirect cost rates indicates a marked difference in DDS organizational structures. As a rule, the higher the indirect cost rate, the greater the level of support services provided by the parent agency.

In Massachusetts, all support services are charged directly to the DDS and not provided by the parent agency. As such, our indirect cost rate is approximately 1.6%, or one of the lowest in the nation. It should be clear that we can not be competitive in PPWY comparative analysis. We will always be significantly below the national average as a result of our organizational structure. We could change our structure and convert many direct costs to the indirect cost mechanism by paper transfer. Although this would markedly increase our PPWY on paper, it would have not effect on our real organizational productivity. This further emphasizes the meaningless of SSA's measurement system. It is subject to manipulation that could render some states as being viewed as productive and others viewed as not productive. Yet, manipulation has no relationship to reality. When SSA states that productivity has increased, one must question the content validity of that statement. Did productivity increase or were paper transfer of staff made in selected locations for the sole purpose of increasing PPWY measurement nationally?

J. LACK OF CONSISTENCY IN DDS OPERATIONS

In addition to variations in indirect costs, other severe variations exist in this purported national program. Examples are as follows:

	CATEGORY	RANGE
A.	Allowance Rate..........	18% to 49%
B.	Total Costs.............	$207 to $438
C.	Indirect Costs Per Weighted Case......	-0- to $59.84
D.	Medical Consultant Productive Hours Per Weighted Case...........	4.2 Minutes to 68 Minutes

The above cited data is obtained from SSA's CEMS Quarterly Report and FD-7 report.

It is most difficult to compare states in terms of productivity when it is obvious that we are not implementing the same program. In Massachusetts, we currently expend approximately 57 minutes of physician time per case. It is not reasonable to assume that we can compete with a state that expends approximately 4 minutes of physician time per case.

Before productivity comparative analysis is conducted among states, SSA must assure that we are all administering the same program in full compliance with the 1984 Disability Benefits Reform Act. The present policies of SSA indicates that physicians must complete the medical evaluation of all cases. It is not reasonable to assume that this can be accomplished in 4 minutes in one state and 68 minutes in another. The Massachusetts DDS has raised this issue to SSA on several occasions over the past 18 months. We still await a response. We have also addressed the inconsistency in allowance rate. Why should an individual residing in Massachusetts have a significantly increased opportunity for disability benefits than an individual residing in many other states across the nation? It seems evident that we do not have a national program. Each DDS develops cases differently and utilizes different types of staff for medical evaluation. In Massachusetts, we remain committed to comprehensive development, documentation and full medical review. Doing otherwise could render us as more productive. However, this increase in productivity would be at the expense of comprehensive services to the disabled citizens of this Commonwealth. This is not a price we are willing to pay.

K. SUMMARY

The rights of disabled individuals to live meaningful and productive lives has been a priority issue for Governor Michael Dukakis and the Commonwealth of Massachusetts. Towards this end, Governor Dukakis directed the Massachusetts Rehabilitation Commission and its Disability Determination Services Division to remedy the crisis created by SSA's accelerated CDR review policies and process of 1981 and 1982. Under the direction of Secretary of Human Services Philip Johnston and Commissioner of Rehabilitation Elmer Bartels, the Massachusetts DDS made marked policy and practice improvements within the DDS. In making such improvements, we worked hand-in-hand with all program constituencies. We developed a well functioning DDS Advisory Committee made up of disabled individuals, legal and private advocates, and others interested in the rights of the disabled. We received outstanding support from the entire Massachusetts Congressional Delegation in its active role regarding the enactment of the 1984 Disability Benefits Reform Act. We also received outstanding support from Massachusetts State Legislators and their staff.

Unfortunately, however, the enactment o the 1984 Reform Act has not ended the crisis. Although the program today has sound policy, resources have not been made available to administer the program in conformance with the intent of the 1984 Reform Act. The Massachusetts DDS has made SSA fully aware of this fact. We have again been supported by our entire Congressional Delegation who has written to SSA Commissioner Dorcas Hardy on two occasions regarding the underfunding and understaffing issues. To date, Commissioner Hardy has not provided a satisfactory response. Rather, the SSA posture remains one of increased productivity even though a satisfactory measurement of productivity does not exist.

The Commonwealth of Massachusetts and its DDS is proud of its accomplishments since 1982. Through the hard work of agency staff and program constituents, we have developed and implemented a program that is consistent with the 1984 Reform Act. We have restored the public confidence that had eroded. Our critics have now become our allies in the administration of this program. Indeed, the Massachusetts DDS has become a public program with public input regarding practices and outcomes.

At the present time, we can ill afford to take a step backward. To do so could mean never regaining public confidence. The 1984 Disability Benefits Reform Act promised a new era of public trust. However, sound policy is only one part of the equation for success. Sound policy must be supported by the availability of necessary resources and consistent national direction. Anything less will result in a mixed message to the American public. Public trust is a key ingredient to programmatic success.

The Commonwealth of Massachusetts encourages the Social Security Administration to examine policies and practices to achieve national consistency. We encourage SSA to re-examine the intent of the 1984 Reform Act and assure compliance nationally. Program variance in terms of allowance rates, costs, medical consultant input, and related factors, can not be ignored in the administration of a national program. In like fashion, the Massachusetts DDS once again requests SSA to improve its budgeting procedures, review and re-define its mental impairment guidelines and course revisions, re-define its CDR goals and related staffing issues, and re-examine its work simplification initiatives that have jeopardized the integrity of the determination process. Finally, the Massachusetts DDS respectfully requests the availability of all necessary resources to implement and manage this important program which affects the lives of thousands of severely disabled individuals in Massachusetts and across the nation. Not doing so will result in a crisis whose magnitude will far exceed that of 1981 and 1982. The disability program can no longer be managed by bandaids. We have placed short term solutions to long range problems. Our bandaids are beginning to snap and the effects are evident in terms of quality, integrity, public confidence and staff morale.

On behalf of the Commonwealth of Massachusetts and its disabled citizens, I wish to thank Chairman Frank and the entire Subcommittee for this opportunity to provide testimony. The Commonwealth of Massachusetts remains committed to the provision of quality disability determination services. Our accomplishments are numerous. I am sure with your assistance we will continue to strive to excellence in our services to and on behalf of disabled individuals.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Social Security Administration
Refer to:
Baltimore MD 21235

FOR RELEASE ONLY UPON DELIVERY

STATEMENT
BY

DORCAS R. HARDY
COMMISSIONER OF SOCIAL SECURITY

BEFORE THE

HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
COMMITTEE ON GOVERNMENT OPERATIONS
U.S. HOUSE OF REPRESENTATIVES

ON

PROGRAM ADMINISTRATION AND PUBLIC SERVICE

JULY 28, 1987

Mr. Chairman and Members of the committee:

I am pleased to appear before you today to discuss the administration of the Social Security program and SSA's service to the public. SSA has an admirable record of administrative excellence and service. My goal as Commissioner is to help the Social Security Administration continue, and improve, its record for providing responsive public service as well as efficient and effective administration and management.

Agency Priorities

I believe that there are several basic ingredients to accomplishing this goal, and I established them as my priorities for the Social Security Administration.

- We must maintain the fiscal integrity of the Social Security programs. Almost all American workers are investing in, and have a vested interest in, Social Security. It must remain in strong financial condition.
- We must continue to provide the best service to our beneficiaries across the country. The American people whose lives we touch deserve prompt, courteous and efficient service, and fair and dignified treatment. I am committed to maintaining high standards in the quality and level of services.
- We should use the best technology available to administer the Social Security programs. I have given priority to continuing the effort to modernize SSA operations and thereby improving SSA's ability to serve its clients.
- We need to recognize and support the vital role of SSA employees as they continue to maintain one of the highest standards of service in the Government. SSA is fortunate in having highly skilled and committed career civil servants--a "family" of workers justly proud of their achievements and dedicated to their mission.
- We should emphasize education of the public so that people understand what they can expect from Social Security. In the recent past, there has been a great deal of concern about the future of Social Security--and steps have been taken to ensure its sound future. But the program requires a high level of public confidence and trust, which can be built only on knowledge. We need to educate workers about their benefits and responsibilities under the system, as well as assure current beneficiaries that their benefits will continue to be paid.

Mr. Chairman, in regard to SSA's service to the public, I want to stress my commitment to maintaining SSA's reputation of providing high-quality service. At the same time, in our effort to maintain the integrity of the Social Security trust funds, it is incumbent on the Social Security Administration to minimize the administrative costs of the program.

I believe that the goals of high-quality service and efficient administration can be accomplished today and in the future through sound overall management and planning. Significant improvements in public service, systems modernization and work processes have already been achieved, and we are on the verge of realizing even greater efficiency and service improvements with the national implementation of the Modernized Claims System. I would like to describe where the agency is today and then look at the challenges ahead.

Improvements in Service Delivery and Work Processing

SSA's performance in getting its work done and serving the public is significantly better today than it was a few years ago, when the agency was threatened as never before with enormous backlogs and delays in processing work. With the help of systems modernization and streamlined processes and procedures, SSA has eliminated its work backlogs and now provides quicker, more accurate service to beneficiaries.

Today, processing times are better than they have ever been and payment accuracy for retirement and survivors claims is 99.6 percent. Postentitlement changes are made to master beneficiary records overnight, rather than in days or weeks. And, major cyclical workloads--such as earnings postings, recomputations of benefits to include additional earnings and cost-of-living increases--are processed in a fraction of the time it took a few years ago.

I would like to mention some of the key improvements.

- Average processing time for retirement and survivors initial claims is 20 days, down from 24 days in 1984.
- Average processing time for SSI aged claims is 11 days, down from 15 days in 1984.
- Posting of 1986 earnings will be completed early next month, just 5 months after they became available, while 1983 earnings took 10 months and 1980 earnings took 15 months to post.

- The time required to make emergency Social Security payments has been reduced from 13 days to 5 days.
- Social Security cards are now issued in just 10 days, where it used to take 6 weeks.

Other indirect systems improvements have increased efficiency, lowered costs, reduced reliance on staff-intensive manual processes and provided SSA with some of the modern tools it needs to do its job, both today and into the future.

Modernized Claims Process

In February of this year we also began nationwide implementation of our Modernized Claims System (MCS). Prior to MCS, putting a new benefit claim into the computer system involved four people: the interviewer who completes a paper application form; the clerk who creates a paper-log control; the data reviewer who prepares a coded data entry sheet; and the teletypist who keys the information into the computer system. Under the new system, one person--the interviewer--can efficiently put the claim into the computer system using a computer terminal on his or her desk.

At the end of this month almost 7500, or 34 percent, of the new terminals will be in place in over 200 field locations. An average of about 70 more field offices will be converted to MCS each month, and all field offices will be operating under the new system by the end of next year. We expect this new claims process not only to improve service by reducing processing time and immediately checking data in our files, but also to reduce staffing requirements. It is through such use of new technology to work "smarter" that we are convinced we can continue to improve service and productivity.

In addition to systems improvements, we are working to increase productivity and service by continuing to improve our procedures and work processes. For example, we have expanded the district office final authorization of initial retirement, survivors and disability claims. This decreases the number of claims referred to our program service centers and speeds up payment of benefits.

Increased Service Availability

We are also trying to make service more easily available to the public in the following ways: scheduling interviews in Social Security offices to reduce waiting times, experimenting with extended office hours to accommodate people who find it inconvenient to conduct business with us during regular working hours, and promoting the use of the telephone as an option to walk-in office visits. Today 35 percent of our Social Security claims are taken over the telephone, versus only 15 percent a year ago, and some areas are far above the national average. For example, Albuquerque, NM is taking 85 percent of its claims by telephone and Jacksonville, FL is handling 74 percent of its claims in that way.

Public's View of Service

Mr. Chairman, while SSA is justifiably proud of these improvements, I want to mention another measure of the progress SSA has made--the marks the public gives the agency. A 1984 General Accounting Office (GAO) survey of the public found that 78 percent of those who have dealt with SSA rated the service as "good to very good." Eighty-nine percent of our clients said that SSA employees were courteous in serving them, and more than half of those surveyed rated SSA's service as better than they received from any other government agency.

A second GAO report on staffing and service quality released in March of this year shows that in a client survey in November 1986, 80 percent of SSA's clients view our service as "good to very good." The positive ratings on employee courtesy and the comparison with other agencies were also up slightly. GAO's survey of SSA employees and managers for its March report found that about 90 percent of both groups said that the service SSA provides is the same or better than 3 years earlier.

I believe that SSA should monitor periodically the public's opinion of the service we deliver. We expect to sign a contract for SSA's first client survey in September. In the meantime, I have asked the HHS Office of the Inspector General to begin this monitoring, and they currently have underway a client survey using the methodology GAO devised. We fully expect that the results of these surveys will indicate, as have the GAO surveys, that SSA is continuing to improve the service it provides to the public.

Management Initiatives

Mr. Chairman, SSA has made a dramatic improvement over the last several years in the areas I have mentioned. While we can take pride in what has been accomplished, I believe that significant further improvement is possible if we have the vision and will to work toward it.

We clearly face significant challenges as we try to improve further SSA's overall management. In this regard, the management review of SSA released by GAO in March of this year was extremely timely. The purpose of the review was to identify SSA management problems that must be addressed to assure the continued delivery of high-quality public service. I agree with the thrust of most of the GAO findings and believe that GAO has provided SSA a useful tool for addressing a wide range of management concerns. Our challenge now is to capitalize on the work GAO has done and make tangible improvements in the way we manage. To this end, I have asked that plans for implementing major recommendations be prepared and tracked closely.

GAO believes that SSA needs both strong and stable leadership and better planning for the future. I agree. Much progress has been made in filling key management vacancies. An agency the size of SSA with such a critical role in the lives of the American people should have strong and stable leadership committed to developing and implementing a plan for the future.

Strategic Plan

One way to help SSA achieve this stability is through a broadly based agreement on the long-term goals of the organization. To fulfill this key objective, we need to formulate a structured and definitive strategic plan to provide the vision and direction that will guide the agency into the future. To do this, I have established an Office of Strategic Planning, reporting directly to me. This office will oversee the development of a 10-15 year strategic plan to guide SSA's development into the next century. The plan is intended to provide a dynamic framework for shaping SSA's future, rather than reacting to it. Our primary goal is the creation of a flexible operational and programmatic environment that provides a high level of efficient and responsive service to the public.

The strategic plan will integrate all of SSA's areas of concern, including systems, operations, policy, data utilization, organizational structure and staffing. For example, the processes for policy formulation, regulations and field instructions all need to be streamlined. Instructions need to be shortened and simplified and the quality of notices to our beneficiaries needs to be improved. We have taken steps to address these extremely important areas.

Systems Modernization

The GAO management report also describes a second management problem--the difficulties the agency has experienced in the systems modernization area, particularly in software development. Earlier I described some of the service improvements which resulted largely from successes in our systems modernization efforts to replace old hardware and upgrade computer capacity. I recognize, however, that we have experienced problems with our progress in upgrading software. Other agencies have also experienced major problems in this area, and given the massive size and complexity of systems supporting Social Security operations, the challenge is especially great.

I can report that we have already made a number of strides in this area. For example, to increase our management control over the systems modernization effort we have developed and put in place uniform software engineering standards for systems personnel to use as they develop and maintain modernized systems. At the same time, we initiated procedures that closely control changes to our hardware and software systems and ensure that our prescribed software engineering practices and standards are used and enforced.

Additionally, we have strengthened the systems integration function to reflect an increased level of effort and emphasis. Improved integration will allow us to better control the hundreds of separate initiatives involved in our modernization efforts to give us better overall management and accountability. Collectively, these initiatives promote more effective management and control on a routine basis of the development and implementation of our modernization program. I have also recently combined overall direction of SSA systems with direction of our operations because the whole purpose of systems activities is to make our operational tasks more accurate and more efficient. Finally, our long-range agency planning efforts will integrate systems modernization with the overall agency plans.

For the immediate future, I have decided that to maximize improvements in service to beneficiaries we must narrow and refocus our systems modernization efforts to emphasize those activities that will provide the greatest service delivery payoff. We will define our objectives in realistic and achievable segments and carefully control the use of resources to ensure that the emphasis on improving service remains the driving force in our systems modernization.

Financial Management

GAO's management review further pointed out the need for SSA to improve its financial management. I agree, and have addressed this recommendation by appointing an SSA Chief Financial Officer, consolidating direction of SSA's financial management under his control, and strengthening our accounting and internal control mechanisms. Also, with the cooperation of GAO and the HHS Office of the Inspector General, financial statements for the Social

Security trust funds will be issued for the first time beginning with fiscal year 1988.

SSA Employees

The final GAO finding I want to discuss is the need for better workforce management. GAO noted that many SSA managers and employees expressed satisfaction with their jobs and demonstrated a high degree of commitment to SSA's mission and its most important objective--providing high-quality service to the public.

GAO also said that SSA has recognized the value of providing a favorable work climate but has not been aggressive enough in producing it. It is very clear to me that SSA's employees are our strongest asset and that their abilities and dedication are essential for SSA to meet its goals. This employee dedication and concern for those we serve are the major reasons the public has expressed satisfaction with the service SSA provides. Improving and maintaining a quality workforce and a favorable work environment are among my highest priorities.

I want our employees to work in modern and professional offices, such as our M Street office in Washington, where the public is served in a comfortable, yet business-like environment. Our employees deserve modern-tools to do their jobs, and we are providing those tools and the training on how to use them. We have also increased the amount of funds available to award employees for high-quality performance.

Mr. Chairman, SSA is clearly in transition from a manual, paper-dominated environment to one where automated systems and advanced communications technology will allow us to provide quicker, more accurate service. I am moving to implement these changes, but I also am committed to helping employees adjust to the new environment with the least possible stress and without any reduction in force. We will take prompt action if problems arise with respect to service levels or the work environment for employees.

Disability Program Management

Mr. Chairman, I would now like to discuss the management of the Social Security and supplemental security income disability programs and implementation of the 1984 disability amendments. We administer the disability programs through 54 State agencies, often referred to as disability determination services (DDSs), who make disability determinations for us.

Let me say at the outset that I believe the administration of the disability program is better than it has been for years. I believe that there is still room for program improvement. We are achieving more cost-effective management while carrying forward the improvements resulting from the 1984 amendments.

Implementation of the 1984 Disability Amendments

The 1984 disability amendments represented a sweeping change for SSA and the DDSs--with perhaps the most dramatic effect on administration of the disability program since we implemented the supplemental security income program in 1974. The amendments are being implemented. In the almost 3 years since the amendments were enacted we have:

- Published and implemented five final regulations including two on the key provisions of the amendments--the medical improvement review standard for continuing disability reviews and the revised standards for evaluating mental impairments;
- Published six regulations on amendment provisions as notices of proposed rulemaking; these should be published as final regulations by this fall;
- Conducted extensive training of DDS adjudicators and carried out special reviews of DDS decisions made under the new rules to make sure decisions accurately follow the rules;
- Largely completed special one-time workloads resulting from rereviews of certain claims required under the medical improvement and mental impairment provisions of the amendments;
- Resumed the continuing disability review process under the medical improvement standard of the amendments with almost 60,000 decisions in fiscal year 1986 and 216,000 expected in fiscal year 1987, and
- Submitted eight reports to Congress on implementation of various provisions of the amendments. These included the report by the congressionally mandated Commission on the Evaluation of Pain which recommended that the 1984 amendment statutory standard for the evaluation of pain be extended until additional studies and experiments on pain and disability recommended by the Commission could be completed.

Because of these accomplishments, the DDSs should be able to return to more normal operations and to work towards meeting goals and priorities I have established.

Goals and Priorities for DDSs

The DDSs are 100 percent federally funded; therefore in regard to management and service to the public I have established similar goals and priorities for the DDSs that I have for SSA. Based on discussions with the DDSs and our operating procedures, I have laid out expectations for a high-quality cost-effective management of the disability process within our budget and for uniform national administration of the program with an equitable deployment of resources among the States.

One of my primary goals is to ensure that the national disability program is administered with equity and compassion as well as a high degree of accuracy. The 1984 amendments were intended to assure more accurate, consistent, and uniform disability decisions at all levels and equitable and humane treatment for beneficiaries and new applicants for benefits. As President Reagan noted when he signed the 1984 amendments into law:

> This legislation, which has been formulated with the support of the Administration and passed by unanimous vote in both Houses of Congress, should restore order, uniformity, and consensus in the disability program. It maintains our commitment to treat disabled American citizens fairly and humanely while fulfilling our obligation to the Congress and the American taxpayers to administer the disability program effectively.

We are actively working with the States on ways to simplify and streamline the determination process and have already put several simplifications in place:

- Encouraging SSA field offices to make the initial contact to obtain claimants' medical evidence of record, thus allowing the DDS to begin case development sooner.

- Emphasizing that SSA field offices must carefully develop the nondisability aspects of the disability claim before forwarding a case to the DDS for development. This saves time spent by the DDS in gathering unnecessary evidence in cases which would be denied on technical grounds.

- Improving the written rationale process to avoid duplication.

- Experimenting with having SSA field offices use claimant self-help interview forms and with having claimants personally forward our requests for evidence to their doctors where appropriate. This does not eliminate SSA's responsibility for assuring that adequate medical evidence is obtained. We use the claimant self-help initiative only when the claimant is able to complete the forms and make the requests.

We are also upgrading DDS automated information systems so that SSA and DDS managers can identify and analyze problems earlier and take swift remedial action.

A recent major initiative to help the DDSs is the creation of a Federal DDS which just began operation. This unit will provide SSA with the ability to assist DDSs in temporary or emergency situations or to take over a State's function if the State is no longer participating in the disability program. The Federal DDS will also improve program management by allowing us to better assess the consistency of our policy directives and the impact and effectiveness of new policies and procedures.

Conclusion

Improving service to our Social Security beneficiaries is my highest priority. Our beneficiaries are our customers. I want our services to be more accessible and responsive to the public now and in the future. Technology is one important vehicle for achieving this goal. We must plan for the future and develop a vision of quality service delivery that will guide our use of technology and our overall agency operation. We know there is still a great deal of work needed to achieve our goals, but we believe our plans are well conceived and will succeed in improving public service and increasing productivity.

Let me assure you that we will regularly and closely monitor our performance to assure that we maintain high-quality public service. We look forward to keeping the Congress informed as we strive to make SSA more effective and efficient in serving the public.

DEPARTMENT OF HEALTH & HUMAN SERVICES [redacted] Social Security Administration

Refer to: SLH-43

[redacted] Memorandum

Date. MAR 2 4 1987

From: Associate Commissioner
for Assessment

Subject: Impact of the Revised Listings for Mental Disorders—INFORMATION

To: Associate Commissioner
for Disability

The attached report contains comprehensive data on disability determination service (DDS) adjudicative performance under the revised listings for mental disorders compared with experience under the prior criteria. The analysis focuses on the impact of the revised listings on DDS allowance rates and accuracy. Since FY 1986 was a year of adjustment to the new medical criteria, the report emphasizes how more recent experience for the period July-December 1986 contrasts with DDS adjudication in the years prior to the introduction of the new rules.

Allowance rate experience under the prior listings and the revised criteria varied considerably by DDS, individual listing category, and beneficiary grouping. Notable variations are discussed in the narrative while a wide range of comparative data spanning several years are included in the tables which follow the narrative.

This evaluation underscores prior findings from QA body system reports that DDS accuracy under the revised listings has deteriorated markedly, particularly among decisions unfavorable to the claimant.

Questions from your staff may be referred to Tom Fohl, Office of Disability Program Quality on extension 40702.

Beverly A. Bedwell
Beverly A. Bedwell

Attachment Df

cc:
Mr. Doggette
Mr. Enoff
Mr. Sabatini

Impact of the Revised Listings for Mental Disorders
Fiscal Year 1986 and July-December 1986

Social Seccurity Administration
Office of Assessment
Office of Disability Program Quality

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A. Methodology for Assigning ICD Codes for FY 1984 and FY 1985 to Revised Listing Categories.
B. Explanation of DDS Basis of Decision Terms

Based on the steps taken by SSA to implement the revised mental rules, nationally, regionally, and by DDS, allowance rates varied considerably during FY 1986. Allowance rates were highest during the introduction of the new criteria when denials were being held. Allowance rates decreased as DDSs began to fully process denial cases. Allowance rates for the 6 months ending 12/86 were at a level which approached DDS experience in FY 1985.

Except where noted, discussion and the data presented refer to cases in which the primary impairment is a mental disorder. Unless specified otherwise, the data exclude cases denied under the prior listings and automatically re-adjudicated under the revised criteria ("code 122" cases).

The method of assessing the impact of the revised criteria is to compare mental allowance rate experience with similar experience under the prior listings in fiscal years 1984 and 1985. Before FY 1986, mental disorders were grouped under a system of four listing categories, none of which was exactly identical to any one of the nine mental listing categories that were utilized in FY 1986. To establish appropriate comparative information, pre-FY 1986 cases were assigned to new listing categories according to their primary diagnosis (actually, a 4-digit ICD diagnostic code) in a manner set forth in Appendix A.

Changes in adjudicative experience on mental impairment cases beginning in FY 1986 may not be attributable solely to the revised criteria. Case adjudication in FY 1986 was influenced by many factors including workload composition, changes in documentation and development practices occasioned by the 1984 disability amendments and policy and procedural changes unrelated to specific mental impairment issues. However, allowance rates in body systems other than mental in FY 1986 suggest that the influence of these factors has been relatively slight.

B. Description of the Quality Assurance Sample

In FY 1986, the DDSs allowed approximately 600,000 of the almost 1,500,000 initial cases adjudicated. The QA sample for the fiscal year included about 20,500 allowances and 17,500 denials. Each QA allowance represented roughly 30 DDS allowance decisions while each QA denial represented roughly 50 DDS denial decisions in FY 1986. The QA data have been weighted to obtain the estimated allowance rates presented in this report.

The precision of estimates obtained from the QA sample varies according to the size of the sample from which the estimate is derived. For example, estimates of national experience are more precise than estimates of individual DDS allowance rates.

II. Impact on Overall Mental Allowance Rates and Accuracy

A. General

The allowance rate for mental disorders in FY 1986 was approximately 60 percent. To gauge the impact of the revised criteria on the FY 1986 rate, a comparative measure is helpful. In the years preceding the revised listings, allowance rates were on an upward trend. During these years, SSA's application of the mental listings was challenged in court. The prior rules also came under scrutiny from sources such as congressional committees, the media, and advocacy groups. On October 9, 1984, legislation was enacted which required the Secretary of Health and Human Services to revise the mental disorders section of the Listing of Impairments. The upward trend in mental allowance rates can be viewed as a response to the scrutiny given SSA's adjudication of mental impairment cases as well as perceived weaknesses in the old criteria which lead to legislation requiring revision.

Mental allowance rates increased from 38.8 percent in FY 1983 to 47.3 percent in FY 1984. In FY 1985, the mental allowance rate reached 52.3 percent which was similar to the rate of 52.7 percent under the revised listings for the period July-December 1986. (Although overall rates for these two periods were similar, individual DDS rates varied widely.)

B. DDS Allowance Rates

Table 1 shows DDS mental impairment allowance rates for fiscal years 1984 through 1986 and the more current period July-December 1986. Comparing the national rates for the latest period with the FY 1985 rate, the revised criteria appears to have had limited impact on mental allowance rates. However, national experience does not reveal the substantial changes which occurred on the DDS level. In the Massachusetts DDS, for example, the 6 month rate of 73.7 percent was considerably higher than the 58.4 percent figure for FY 1985. In Pennsylvania, the recent rate of 38.7 percent was markedly lower than the FY 1985 rate of 54.3 percent. Relatively wide swings (higher or lower) also occurred in Vermont, Puerto Rico, the District of Columbia, Maryland, West Virginia, Kentucky, Tennessee, Arkansas, New Mexico, Iowa, North Dakota, Wyoming, Arizona, and Washington.

The wide fluctuations suggest that DDSs were not consistently applying the revised criteria. The recent rates must be viewed as preliminary estimates of actual experience since they were based generally on 75-100 mental sample cases per DDS. However, QA accuracy rates, which are discussed later, reinforce the findings suggested by the DDS allowance rate data that DDSs were not applying the revised criteria appropriately.

C. Disability Insurance vs. Supplemental Security Income Disability Beneficiaries

In FY 1985, disability insurance beneficiaries (title II only and concurrent II/XVI) made up about 45.6 percent of the mental impairment allowance decisions. In the 6 month period ending December 1986, the proportion increased to 49.2 percent. The percentage of supplemental security income beneficiaires (title XVI only) in mental impairment allowance decisions for the two periods decreased proportionately from 54.4 percent to 50.8 percent.

Mental impairment allowance rates for disability insurance beneficiaries increased from FY 1985 to July-December 1986, while the rates for supplemental security income recipients showed a slight decline. The largest increase occurred in title II only allowances where the allowance rate went from 55.9 to 60.2 percent (table 3).

D. Beneficiary Category

All the major workload categories - title II workers, title XVI disabled individuals, and concurrent workers/disabled individuals - showed increases under the revised listings (table 3). Of these, title II only workers showed the largest increase from 48.7 percent to 54.8 percent.

Allowance rates for title II only childhood disability beneficiaries remained virtually unchanged under the revised criteria. The listings for title XVI disabled children did not undergo revision, and allowance rates for this category were lower. Rates for title XVI disabled spouses and some concurrent classifications were also lower.

E. Basis for the DDS Decision

When mental impairment allowance cases for July 1986-December 1986 are distributed according to the basis for the DDS determination (table 6), a greater proportion "met" the listing criteria (about 76 percent) than did in FY 1985 (about 65 percent). The increase in the proportion of "meets" cases was mostly offset by a decrease in proportion of cases in which medical and vocational factors came into play in the allowance decision. There was very little change in the proportion (about 5 percent) of "equals" allowances.

As for denials (table 7) a direct comparison with prior data is not as meaningful. In several jurisdictions, courts have required SSA to eliminate the "not severe" step in sequential evaluation. As a consequence, the proportion of "not severe" cases under the new criteria has dropped substantially from prior levels (especially pre-FY 1985 levels). Cases which would have been denied as "not severe" in the jurisdictions affected by court orders, appear in other DDS basis categories.

F. Mental Impairment Workloads

As noted, the focus of this analysis is on allowance rates and accuracy. Estimated workloads by body system (including mental impairment cases) are regularly reported to the Office of Disability. Tables 9 and 10 provide estimated numbers of DDS decisions in a manner not routinely reported. Table 9 shows estimated DDS initial and reconsideration decisions for the mental body system beginning with FY 1984 and includes actual total workloads as reported on the State Agency Operations Report (SAOR). In FY 1985, cases with a mental disorder as the primary impairment comprised almost 22 percent of DDS initial and reconsideration decisions. In FY 1986, this figure was a little over 23 percent. For the 6 months ending December 1986, the proportion exceeded 25 percent. Table 10 provides estimated workloads and allowance rates for cases with a mental disorder as a secondary impairment. The estimated number of cases with a secondary mental impairment in body systems other than mental has more than doubled from FY 1985 to FY 1986.

IV. Return Rates for Allowances and Denials

Mental body system return rates* reflect a decrease in accuracy under the revised listings. Historical return rates follow for mental cases and all other body systems.

Return Rates for Mental Impairments vs. Other Impairments

	Mental Impairments	All Other Impairments
FY 1984		
Allowances	3.0%	4.2%
Denials	9.5	4.1
FY 1985		
Allowances	2.5	3.3
Denials	7.2	3.4
FY 1986		
Allowances	4.6	3.9
Denials	17.0	5.5
7/86-12/86		
Allowances	4.2	4.3
Denials	14.8	5.6

The above rates include "grace period" deficiencies which are not counted in computing QA accuracy rates for measuring DDS performance.

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*The percentage of cases reviewed which were returned to the DDSs for further action because of decisional or documentation deficiencies.

Return rates for impairments other than mental for the 6 months ending December 1986 have increased over FY 1985 levels. For the "all other" body systems category the allowance return rate increased by one percentage point while the denial return rate increased about two points. The experience in the mental body system differed markedly for denials. The return rate for mental denials more than doubled to 14.8 percent, an increase of over 7 percentage points.

It is apparent that the revised listings have had a profound downward impact on denial accuracy. Return rates for the revised listings by the basis for the DDS denial (table 12) as well as regional return rates by listing category (table 14) underscore the fact that high return rates for denials are a widespread problem.

More specifically, in the July-December 1986 period, denial return rates for the individual listings ranged from a low of 10.4 percent for listing 12.08 (personality disorders) to a high of 29.5 percent for listing 12.03 (schizophrenic, paranoid, and other psychotic disorders). In the basis of decision categories, denial return rates ranged from 10.5 percent for the "other" category (explained in Appendix B) to 20.6 percent for claimants denied on the basis of ability to do past work. Regional return rates by individual listing categories were generally high in most listing categories (Additional discussion of return rates by individual listing categories appears in section IV. A-H.)

In FY 1985, about 70 percent of the QA denials returned to the DDSs were reversed to allowances. If similar reversal experience applies to the QA mental denials, it would suggest that a large number of DDS mental denials should be allowances.

V. Impact of the Listings by Specific Listing Category

A. Listing 12.02 - Organic Mental Disorders

This listing covers psychological or behavioral abnormalities associated with a dysfunction of the brain. Medical history and physical examination or laboratory tests are used to demonstrate the presence of a specific organic factor causing the abnormal state and lost of previously acquired functional abilities.

Organic mental disorders comprised about 8 percent of the mental impairment workload for the recent July-December period. The allowance rate for this category of 69.1 percent was similar to the FY 1985 rate. However, a much higher proportion of allowances (71.9 percent) met the revised listing criteria than met the prior criteria (51.4 percent). In FY 1986, regional allowance rates ranged from 62.0 percent to 95.8 percent.

Return rates for allowances in this listing were below the average for all mental allowances in the July-December period. "Meets" cases had a relatively low return rate of 1.8 percent. The return rate for denials (15.8 percent) was slightly above the average for mental denials (14.8 percent).

B. Listing 12.03 - Schizophrenic, Paranoid and Other Psychotic Disorders

These conditions are characterized by the onset of psychotic features such as delusions, grossly disorganized behavior, incoherence, or emotional withdrawal with deterioration from a prior level of functioning.

This listing comprised almost 19 percent of decisions in the mental body system for the 6 months ending December 1986. The allowance rate of 71 percent for this period was substantially higher than the FY 1985 rate of 62.7 percent. About 94 percent of allowances met the revised listing criteria vs. less than 60 percent under the prior listings. In FY 1986 regional allowance rates ranged from 69 percent to almost 95 percent.

Return rates for allowances (2.1 percent) for the July-December 1986 period were the lowest of any of the eight listing categories. On the other hand, the denial return of 29.5 percent was the highest of the eight categories.

C. Listing 12.04 - Affective Disorders

These disorders are characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves depression or elation.

Affective disorders comprised almost 20 percent of decisions in the mental body system from July-December 1986. The allowance rate for the period of 39.2 percent was up from the FY 1985 rate of about 35 percent. About two-thirds of allowances met the revised listing criteria while less than two-fifths met the prior criteria in FY 1985. In FY 1986, regional allowance rates ranged widely from a low of about 29 percent to a high of over 73 percent.

The return rate for allowances of 6.2 percent was above average for all mental allowances and the "meets" category showed a particularly high rate of 5.4 percent (the return rate for all mental cases in the "meets" category was 3.1 percent). The denial return rate was about average for mental denials.

D. Listing 12.05 - Mental Retardation and Autism

Mental retardation refers to significantly subaverage general intellectual functioning with deficits in adaptive behavior manifested during the developmental period (before age 22). Listing 12.05D is newly included in the listing for mental retardation and covers autism. Autism is a pervasive developmental disorder characterized by social and significant communication deficits originating in the developmental period.

This is the highest workload listing with about 35 percent of the mental body system cases for period July-December 1986. The allowance rate for the period of about 61 percent was lower than the FY 1985 rate of almost 68 percent. The percentage of cases meeting the revised criteria (about 82 percent) was similar to the percentage under the prior criteria. In FY 1986, regional allowance rates ranged from about 57 percent to almost 83 percent.

Return rates in this category for allowances and denials in the 6 month period ending December 1986 were both below the averages for all mental allowances and denials.

E. Listing 12.06 - Anxiety Related Disorders

In these disorders, anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms e.g., confronting the dreaded object or situation in a phobic disorder. An anxiety related disorder may result in complete inability to function independently outside of the home.

About 5 percent of mental body system decisions for the 6 months ending December 1986 were anxiety related disorders. The allowance rate of 30.4 percent for the period was above the FY 1985 rate of about 24 percent. Over one-half of the allowances met the revised listing criteria while only about one-quarter met the prior criteria in FY 1985.

The return rate for allowances of 8.3 percent in the period July-December 1986 was nearly double the average for all mental allowances. The denial return rate of 13.0 percent was a little below the average for all mental denials.

F. Listing 12.07 - Somatoform Disorders

These disorders are characterized by physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms.

Only about one percent of decisions in the mental body system during July-December 1986 fell under this listing category. The allowance rate of about 24 percent in the period was similar to the rate for FY 1985. About 35 percent of the allowances met the revised listing criteria vs. the figure of about 14 percent in FY 1985. However too few allowances were reviewed from July-December 1986 to draw firm conclusions about allowance rates and basis of decision categories. Also, too few cases under this listing were reviewed during July-December 1986 to provide reliable data on return rates.

G. Listing 12.08 - Personality Disorders

A personality disorder exists when personality traits are inflexible, maladaptive and cause either significant impairment in social or occupational functioning or subjective distress.

About 9 percent of mental body system decisions were personality disorders. The allowance rate of 25 percent for the 6 months ending December 1986 was similar to the rate for FY 1985. The percentage of cases which met the listingg criteria (37.2 percent) was up from the level in FY 1985 (27.2 percent). This listing had the highest percentage of allowances which equalled the revised criteria (10.7 percent).

The return rate for allowances in this listing was above average at 7.4 percent for the period July-December 1986. The denial return rate of 10.4 percent was the lowest for any listing category in this period.

H. Listing 12.09 - Substance Addiction Disorders

These are behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system. The severity of impairment for some cases under this listing is determined under the requirements of other, non-mental, listing criteria. For example, individuals with a substance addiction disorder having liver damage are evaluated under Listing 5.05-chronic liver disease.

About 5 percent of mental body system decisions in the 6 months ending December 1986 were substance addiction disorders. The allowance rate for the period of 16.5 percent is considerably higher than the rate of about 6 percent in FY 1985. A little over 50 percent of allowances met the revised listing criteria while less than 20 percent met the prior criteria in FY 1985.

Although only 47 allowances were reviewed for the 6 month period, it is evident that allowances are highly error-prone in this listing considering the allowance return rates of 23.1 percent in FY 1986 (based on 91 cases) and 17 percent for July-December 1986. The denial return rate of 11.2 percent was below the average for all denials.

VI. Summary of Significant Findings

1. Although the allowance rate of 52.7 percent for the 6 months ending December 1986 under the revised listings approximated the mental body system allowance rate of 52.3 percent for FY 1985 under the prior listings, individual DDS rates often varied widely for the two periods.

2. Comparing the recent 6 month period with FY 1985, the revised criteria had the greatest impact on title II only cases with an increase of about 4 percentage points in allowance rates. Title XVI allowance rates for the two periods decreased slightly while concurrent rates showed a small increase.

3. Allowance rate changes for the two periods varied widely by beneficiary category. For example, the allowance rate for title II only workers increased around 6 percentage points while the rate for title II only childhood disability beneficiaries remained about the same.

4. A greater proportion of mental body system allowances "met" the revised listings (about 76 percent) than did the prior criteria (about 65 percent). The increase in the "meets" category was mostly offset by a decrease in proportion of allowance cases in which medical and vocational factors came into play.

5. Mental body system accuracy is much lower under the revised listings than under the prior criteria. The decrease in accuracy is substantial among DDS mental disorder decisions which are unfavorable to the claimant. As such, efforts to improve the accuracy of decisions in the mental body system need to focus on denial cases.

6. Since implementation of the revised listings, a greater proportion of the DDS workload of initial and reconsideration cases consists of cases with a primary impairment in the mental body system. In FY 1985 mental cases comprised almost 22 percent of DDS initial and reconsideration decisions. For the period July-December 1986, the proportion was over 25 percent. In addition, increasing numbers of initial cases in other body systems have a mental disorder as a secondary impairment.

7. In light of high QA denial return rates, allowance rates under the revised listing criteria may be understated.

Table 1

Estimated DDS Allowance Rates for Mental Impairment Cases

	FY 1984	FY 1985	FY 1986	7-12/86
NATIONAL	47.3	52.3	60.2	52.7
BOSTON	49.0	55.5	69.1	64.6
Connecticut	40.2	51.1	74.1	56.2
Maine	61.7	56.4	56.7	47.2
Massachusetts	45.8	58.4	73.5	73.7
New Hampshire	60.2	62.6	65.3	62.8
Rhode Island	64.8	51.5	55.2	54.4
Vermont	48.2	42.2	51.8	51.1
NEW YORK	40.7	48.6	48.0	49.7
New Jersey	52.2	62.7	65.9	56.2
New York	38.8	47.0	44.0	48.3
Puerto Rico	31.1	31.3	51.4	44.5
PHILADELPHIA	39.5	46.9	52.9	43.4
Delaware	52.4	58.6	77.4	64.2
District of Columbia	48.9	44.3	73.6	57.6
Maryland	42.0	41.2	63.0	62.3
Pennsylvania	35.6	54.3	49.1	38.7
Virginia	41.6	46.1	54.1	48.8
West Virginia	41.8	37.3	43.5	25.1
ATLANTA	47.3	47.6	58.5	51.3
Alabama	40.7	54.0	66.7	57.6
Florida	51.4	58.8	68.6	55.7
Georgia	45.0	44.5	56.7	43.5
Kentucky	43.7	43.9	51.6	57.0
Mississippi	47.7	41.2	54.2	39.5
North Carolina	49.7	50.4	57.1	56.0
South Carolina	53.3	50.2	61.0	55.4
Tennessee	46.8	32.4	44.5	43.5
CHICAGO	60.3	63.6	75.2	64.2
Illinois	43.6	54.3	74.7	55.9
Indiana	54.6	67.9	82.2	67.5
Michigan	64.7	57.1	73.8	61.4
Minnesota	71.3	69.1	71.8	70.9
Ohio	71.8	69.8	79.7	72.1
Wisconsin	64.0	74.6	68.3	63.5
DALLAS	43.0	46.5	64.4	44.7
Arkansas	41.4	49.0	48.4	37.9
Louisiana	38.1	33.1	42.9	27.1
New Mexico	44.0	54.8	60.8	41.0
Oklahoma	41.9	52.7	65.8	45.6
Texas	46.9	51.9	80.9	59.0
KANSAS CITY	43.3	47.4	55.1	44.9
Iowa	52.5	51.3	53.2	36.9
Kansas	48.6	54.6	51.1	51.8
Missouri	36.9	42.8	58.9	47.6
Nebraska	46.8	48.3	49.6	41.6
DENVER	42.5	58.4	67.7	61.0
Colorado	36.2	57.0	70.8	66.2
Montana	38.8	42.7	50.1	38.2
North Dakota	50.6	55.9	76.1	75.1
South Dakota	47.8	56.2	57.9	56.5
Utah	54.2	66.2	71.6	62.7
Wyoming	44.3	75.6	73.5	62.2
SAN FRANCISCO	50.8	59.1	51.9	53.0
Arizona	73.5	71.0	65.7	57.4
California	47.6	58.5	51.0	52.6
Hawaii	54.4	52.0	46.7	54.5
Nevada	48.5	48.1	44.6	48.7
SEATTLE	33.3	34.3	53.0	46.7
Alaska	45.8	44.9	56.3	51.2
Idaho	46.0	45.6	65.7	50.7
Oregon	26.1	26.7	44.7	33.0
Washington	34.6	36.2	56.8	53.0

Table 2

ESTIMATED ALLOWANCE RATES BY MENTAL LISTING

Mental Listing Category and Listing Number	Allowance Rates			
	FY 84	FY 85	FY 86	7-12/86
Organic Mental Disorders (12.02)	64.2	68.5	77.3	69.1
Schizophrenic, Paranoid and Other Psychotic Disorders (12.03)	52.8	62.7	78.5	71.0
Affective Disorders (12.04)	28.5	34.7	48.0	39.2
Mental Retardation and Autism (12.05)	66.4	67.7	68.6	60.8
Anxiety Related Disorders (12.06)	14.9	23.7	37.1	30.4
Somatoform Disorders (12.07)	15.9	22.4	31.2	24.1
Personality Disorders (12.08)	18.0	26.5	32.2	25.0
Substance Addiction Disorders (12.09)	5.5	5.9	18.5	16.5
All Mental Impairments	47.3	52.3	60.2	52.7

Note: Before FY 1986 mental disorders were grouped under four listings categories, none of which corresponded exactly with an FY 1986 category. Pre FY 1986 cases were assigned to new listing categories according to their primary diagnoses.

Table 3

ESTIMATED ALLOWANCE RATES FOR MENTAL IMPAIRMENT CASES BY BENEFIT CATEGORY

BENEFIT CATEGORY	ALLOWANCE RATES			
	FY 84	FY 85	FY 86	7-12/86
TITLE II ONLY				
Worker	41.4	48.7	61.0	54.8
Disabled Widow(er)	42.3	42.5	58.2	55.0
Childhood Disability (CDB)	78.2	80.4	85.8	80.1
Medicare	100.0	50.9	100.0	100.0
All Title II Only	51.3	55.9	66.2	60.2
XVI ONLY				
Disabled Individual	46.1	52.9	62.9	55.8
Disabled Spouse	44.0	49.3	60.7	44.7
Disabled Child	58.6	61.9	57.8	53.2
All XVI Only	50.8	55.2	61.1	54.9
CONCURRENT				
Worker/SSI	32.2	40.1	54.5	43.4
Disabled Widow(er) SSI	36.7	44.2	48.7	43.5
CDB/SSI	44.6	52.3	54.4	39.3
Medicare	28.0	100.0	50.3	24.4
All Concurrents	37.2	41.8	53.9	43.0
All Categories	47.3	52.3	60.2	52.7

Fiscal Year 1986 [illegible]

	12.02 (Organic)	12.03 (Schizophrenic Paranoid)	12.04 (Affective)	12.05 (Retardation Autism)	All Other*
National	77.3	78.5	48.0	68.6	29.9
Boston	77.4	86.7	60.9	82.7	45.9
Connecticut	69.8	86.1	73.5	86.7	48.1
Maine	53.4	84.2	44.6	65.0	34.5
Massachusetts	84.1	90.7	63.0	95.8	50.4
New Hampshire	83.3	72.2	61.3	75.5	36.5
Rhode Island	70.8	80.8	44.5	61.0	33.6
Vermont	80.9	85.0	32.6	63.8	31.2
New York	95.8	84.8	45.6	57.1	12.3
New Jersey	89.3	82.1	48.2	69.4	42.9
New York	100.0	85.9	47.0	54.1	9.0
Puerto Rico	100.0	84.1	27.9	90.3	11.8
Philadelphia	62.0	70.0	39.9	67.8	21.6
Delaware	78.5	80.5	66.9	85.6	65.5
District of Columbia	66.4	77.7	75.0	94.8	30.8
Maryland	77.2	79.6	48.2	75.6	42.1
Pennsylvania	50.3	70.6	32.3	69.8	19.9
Virginia	60.2	58.6	40.5	71.3	15.4
West Virginia	72.6	71.5	55.3	48.8	9.6
Atlanta	76.3	76.6	47.1	68.1	22.0
Alabama	100.0	63.6	50.2	73.3	54.7
Florida	73.4	82.8	58.8	87.3	31.4
Georgia	92.9	86.2	35.6	63.1	20.4
Kentucky	68.0	100.0	33.1	64.8	15.4
Mississippi	78.0	73.0	28.4	64.3	8.4
North Carolina	60.2	77.8	27.6	70.4	18.4
South Carolina	100.0	70.5	40.3	69.1	41.9
Tennessee	66.2	59.3	45.9	51.8	8.9
Chicago	93.7	94.7	73.1	77.7	48.1
Illinois	88.5	93.3	68.9	79.0	43.1
Indiana	100.0	100.0	90.0	79.0	49.9
Michigan	89.8	92.4	69.6	69.9	58.7
Minnesota	85.2	91.5	67.4	47.7	38.6
Ohio	100.0	100.0	76.7	92.6	46.7
Wisconsin	87.4	90.6	75.5	64.1	51.6
Dallas	81.4	76.5	44.8	64.4	44.9
Arkansas	61.5	79.1	18.6	57.1	11.8
Louisiana	81.8	59.5	20.6	43.8	28.0
New Mexico	74.4	100.0	38.8	66.4	42.5
Oklahoma	100.0	90.0	58.5	67.9	46.3
Texas	81.9	81.0	70.1	84.0	66.8
Kansas City	78.6	69.8	47.4	64.3	22.0
Iowa	81.4	66.9	44.2	59.7	30.1
Kansas	80.9	63.8	16.7	64.6	15.8
Missouri	78.0	78.7	59.7	66.0	19.6
Nebraska	46.3	49.4	40.3	68.7	21.9
Denver	83.7	84.9	59.8	74.9	39.7
Colorado	92.7	85.5	63.6	82.8	39.4
Montana	59.5	77.0	32.6	60.1	21.9
North Dakota	93.3	75.0	83.0	82.9	42.4
South Dakota	75.4	80.4	41.2	62.5	40.6
Utah	72.4	95.1	60.9	73.4	48.4
Wyoming	91.1	78.0	74.8	76.5	52.2
San Francisco	76.3	68.8	29.0	82.0	29.5
Arizona	76.7	78.9	53.7	79.4	44.2
California	76.2	68.0	27.8	82.6	29.4
Hawaii	78.5	69.1	28.3	84.7	18.4
Nevada	79.5	57.1	10.6	68.9	12.9
Seattle	77.4	80.5	42.2	66.3	19.5
Alaska	56.3	80.5	37.0	66.7	32.4
Idaho	88.5	88.0	31.9	73.4	38.6
Oregon	65.0	72.7	30.8	64.9	14.0
Washington	82.9	84.1	31.2	65.4	20.5

NOTE: Since relatively few cases were sampled in each listing category on the DDS level, the DDS allowance rates by listing are only broad indicators of adjudicative experience.

*Includes anxiety, somatoform, personality, substance addition disorders, and listings applicable only on title XVI disabled children

Table 5

DDS CE SAMPLE SIZES BY MAJOR LISTINGS
Fiscal Year 1986

	12.02 (Organic)	12.03 (Schizophrenic Paranoid)	12.04 (Affective)	12.05 (Retardation Autism)	All Other*
National	912	2,014	1,608	3,644	1,565
Boston	77	211	182	293	201
Connecticut	14	54	36	48	32
Maine	15	32	35	55	32
Massachusetts	15	26	31	29	36
New Hampshire	8	36	28	51	23
Rhode Island	12	31	28	56	31
Vermont	13	32	24	54	47
New York	29	134	124	200	102
New Jersey	13	53	35	51	27
New York	6	40	28	78	48
Puerto Rico	10	41	61	71	27
Philadelphia	176	242	166	418	154
Delaware	15	39	29	68	25
District of Columbia	23	72	21	55	18
Maryland	27	38	31	48	29
Pennsylvania	11	36	31	50	30
Virginia	26	37	20	84	21
West Virginia	74	20	34	113	31
Atlanta	132	290	216	670	143
Alabama	8	35	24	83	12
Florida	14	46	37	48	18
Georgia	30	30	38	77	22
Kentucky	18	20	26	90	20
Mississippi	10	47	20	111	16
North Carolina	19	45	29	85	17
South Carolina	9	34	23	50	13
Tennessee	24	33	19	86	25
Chicago	124	294	272	457	261
Illinois	29	51	34	61	35
Indiana	19	35	28	84	22
Michigan	14	57	44	49	28
Minnesota	22	64	62	96	54
Ohio	18	48	43	62	45
Wisconsin	22	39	61	105	77
Dallas	77	182	123	436	131
Arkansas	9	28	15	106	22
Louisiana	14	42	21	114	17
New Mexico	21	38	37	66	43
Oklahoma	13	36	33	70	29
Texas	20	38	17	80	20
Kansas City	58	141	99	292	125
Iowa	15	32	37	96	41
Kansas	20	47	19	72	30
Missouri	14	29	21	60	24
Nebraska	9	33	22	64	30
Denver	101	226	207	487	191
Colorado	18	36	44	53	34
Montana	13	34	25	61	26
North Dakota	19	30	23	98	26
South Dakota	14	30	28	95	35
Utah	17	50	41	75	28
Wyoming	20	46	46	105	42
San Francisco	75	166	130	182	140
Arizona	21	39	28	48	22
California	26	61	50	62	50
Hawaii	13	50	34	39	53
Nevada	15	16	18	33	15
Seattle	63	128	89	209	117
Alaska	15	35	14	39	27
Idaho	11	21	22	65	22
Oregon	18	41	33	66	36
Washington	19	31	20	39	32

*Includes anxiety, somatoform, personality, substance addiction disorders, and listings applicable only to title XVI disabled children.

Table 6

PERCENTAGE DISTRIBUTION OF MENTAL LISTINGS BY DDS BASIS OF DECISION ALLOWANCES

Mental Listing Category and Listing Number	Period	Basis* of DDS Allowances			
		Meets	Equals	Med. Voc.	Total Allowances
Organic Mental Disorders (12.02)	FY 1984	55.9	10.5	33.6	100.0
	FY 1985	51.4	9.7	38.9	100.0
	FY 1986	74.6	6.3	19.1	100.0
	7-12/86	71.9	6.6	21.5	100.0
Schizophrenic, Paranoid and Other Psychotic Disorders (12.03)	FY 1984	63.6	4.1	32.3	100.0
	FY 1985	59.1	4.7	36.2	100.0
	FY 1986	86.5	3.0	10.5	100.0
	7-12/86	84.4	3.2	12.4	100.0
Affective Disorders (12.04)	FY 1984	45.4	7.8	46.8	100.0
	FY 1985	39.1	5.4	55.5	100.0
	FY 1986	66.3	6.3	27.4	100.0
	7-12/86	66.3	4.3	29.4	100.0
Mental Retardation and Autism (12.05)	FY 1984	86.1	3.3	10.6	100.0
	FY 1985	81.5	4.1	14.4	100.0
	FY 1986	83.5	4.5	12.0	100.0
	7-12/86	82.8	4.8	12.4	100.0
Anxiety Related Disorders (12.06)	FY 1984	27.2	6.5	66.3	100.0
	FY 1985	25.3	9.0	65.7	100.0
	FY 1986	57.1	5.2	37.7	100.0
	7-12/86	51.2	4.8	44.0	100.0
Somatoform Disorders (12.07)	FY 1984	54.1	16.7	29.2	100.0
	FY 1985	14.3	16.7	69.0	100.0
	FY 1986	39.3	3.6	57.1	100.0
	7-12/86	35.3	5.9	58.8	100.0
Personality Disorders (12.08)	FY 1984	33.1	9.7	57.2	100.0
	FY 1985	27.2	8.5	64.3	100.0
	FY 1986	44.9	7.9	47.2	100.0
	7-12/86	37.2	10.7	52.1	100.0
Substance Addiction Disorders (12.09)	FY 1984	28.6	17.1	54.3	100.0
	FY 1985	18.4	13.2	68.4	100.0
	FY 1986	44.0	7.7	48.3	100.0
	7-12/86	51.1	6.4	42.5	100.0
Listings 12.02-12.09 Combined	FY 1984	71.3	4.9	23.8	100.0
	FY 1985	65.2	5.2	29.6	100.0
	FY 1986	77.7	4.8	17.5	100.0
	7-12/86	75.9	4.8	19.3	100.0

*See Appendix for definitions of basis categories.

Table 7

PERCENTAGE DISTRIBUTION OF MENTAL LISTINGS BY DDS BASIS OF DECISION DENIALS

Mental Listing Category and Listing Number	Period	Basis* of DDS Denials					
		Not Severe	Can Do Past Work	Can Do Other Work	Duration	Other	Total Denials
Organic Mental Disorders (12.02)	FY 1984	27.7	20.1	30.9	11.9	9.4	100.0
	FY 1985	14.9	26.1	41.0	10.5	7.5	100.0
	FY 1986	10.0	29.2	27.5	11.7	21.6	100.0
	7-12/86	9.2	31.6	21.1	15.8	22.3	100.0
Schizophrenic, Paranoid and Other Psychotic Disorders (12.03)	FY 1984	17.5	23.6	31.0	18.5	9.4	100.0
	FY 1985	11.6	27.5	32.9	16.4	11.6	100.0
	FY 1986	74.9	26.5	27.6	16.4	14.6	100.0
	7-12/86	18.1	29.5	22.3	17.5	12.7	100.0
Affective Disorders (12.04)	FY 1984	24.0	20.8	34.8	14.7	5.7	100.0
	FY 1985	16.9	28.1	35.5	12.0	7.5	100.0
	FY 1986	15.4	29.0	31.1	10.6	13.9	100.0
	7-12/86	14.8	29.6	34.8	9.9	10.9	100.0
Mental Retardation and Autism (12.05)	FY 1984	5.8	23.8	39.5	1.4	29.5	100.0
	FY 1985	3.4	26.8	38.9	1.7	29.2	100.0
	FY 1986	7.1	19.8	27.4	1.2	44.5	100.0
	7-12/86	6.7	20.2	30.4	1.7	41.0	100.0
Anxiety Related Disorders (12.06)	FY 1984	41.1	15.3	32.4	7.9	3.3	100.0
	FY 1985	25.5	26.6	36.7	3.6	7.6	100.0
	FY 1986	26.5	25.4	32.6	6.1	9.4	100.0
	7-12/86	22.2	26.9	39.8	5.6	5.5	100.0
Somatoform Disorders (12.07)	FY 1984	44.1	21.2	21.2	7.7	5.8	100.0
	FY 1985	16.5	36.4	35.5	4.1	7.5	100.0
	FY 1986	27.5	43.5	20.3	4.3	4.4	100.0
	7-12/86	20.0	43.3	33.3	0.0	3.4	100.0
Personality Disorders (12.08)	FY 1984	31.0	21.2	33.5	6.7	7.6	100.0
	FY 1985	17.2	36.6	35.0	2.4	8.8	100.0
	FY 1986	17.7	30.8	34.1	3.3	14.1	100.0
	7-12/86	10.4	28.7	40.1	5.0	15.8	100.0
Substance Addiction Disorders (12.09)	FY 1984	47.8	17.6	12.2	9.4	13.0	100.0
	FY 1985	28.4	28.4	28.4	5.1	9.7	100.0
	FY 1986	19.2	38.8	21.0	6.7	14.3	100.0
	7-12/86	20.9	33.6	22.4	5.2	17.9	100.0
Listings 12.02-12.09 Combined	FY 1984	21.0	21.6	32.8	10.6	14.0	100.0
	FY 1985	13.7	28.4	35.6	7.9	14.4	100.0
	FY 1986	14.4	27.3	28.8	6.8	22.7	100.0
	7-12/86	13.3	27.5	31.4	7.2	20.6	100.0

*See Appendix for definitions of basis categories.

Table 6

QA SAMPLE SIZES BY MENTAL LISTING CATEGORY

Mental Listing Category and Listing Number	Period	Allowances Reviewed	Denials Reviewed
Organic Mental Disorders (12.02)	FY 1984	697	159
	FY 1985	774	295
	FY 1986	732	120
	7-12/86	303	76
Schizophrenic, Paranoid and Other Psychotic Disorders (12.03)	FY 1984	2,279	836
	FY 1985	2,413	1,192
	FY 1986	1,746	268
	7-12/86	723	166
Affective Disorders (12.04)	FY 1984	787	809
	FY 1985	953	1,493
	FY 1986	1,008	610
	7-12/86	419	365
Mental Retardation and Autism (12.05)	FY 1984	4,177	867
	FY 1985	4,275	1,691
	FY 1986	2,870	736
	7-12/86	1,106	401
Anxiety Related Disorders (12.06)	FY 1984	92	216
	FY 1985	166	444
	FY 1986	191	181
	7-12/86	84	108
Somatoform Disorders (12.07)	FY 1984	24	52
	FY 1985	42	121
	FY 1986	56	69
	7-12/86	17	30
Personality Disorders (12.08)	FY 1984	175	326
	FY 1985	235	540
	FY 1986	284	334
	7-12/86	121	202
Substance Addiction Disorders (12.09)	FY 1984	35	245
	FY 1985	38	507
	FY 1986	91	224
	7-12/86	47	134
Listings 12.02-12.09 Combined	FY 1984	8,266	3,510
	FY 1985	8,896	6,283
	FY 1986	6,978	2,542
	7-12/86	2,820	1,482

Table 9

Estimated DDS Initial & Reconsideration Mental Workloads And Favorable Decision Rates

	FY 1984	FY 1985	FY 1986	7-12/86
Initial & Reconsideration Cases (Total Decisions-All Body Systems)	1,748,110	1,769,328	1,825,504	1,007,548
Mental Body System	412,500	386,900	423,200	254,300
Favorable Mental Decisions	173,600	182,200	235,300	118,600
Favorable Mental Rate	42.1	47.1	55.6	46.6

SOURCE: Total initial and reconsideration workloads are from the State Agency Operations Report (SAOR). Mental figures are estimates based on the quality assurance sample.

Table 10

Estimated Number of Cases with Mental as a Secondary Impairment

Primary Body System	Estimated Workloads*		Allowance Rates	
	FY'85	FY'86	FY'85	FY'86
Musculoskeletal	11,200	27,600	11.6	8.1
Special Senses	1,100	3,500	41.2	36.9
Respiratory	2,100	3,600	17.4	18.7
Cardiovascular	4,400	7,700	15.5	16.1
Digestive	1,700	3,000	18.2	30.9
Genito-Urinary	200	800	11.3	21.8
Hemic-Lymphatic	100	300	53.1	21.8
Skin	100	200	0	0
Endocrine	1,100	2,600	9.5	18.8
Multiple	800	1,600	4.2	18.3
Neurological	6,500	14,300	34.6	36.0
Mental	51,700	78,100**	49.7	58.6
Neoplastic	500	1,100	33.5	35.9
Growth Impairment (XVI)	100	100	43.6	100.0
All Body Systems	81,600	144,500	38.6	40.7
All Body Systems Less Mental	29,900	66,400	19.2	19.7

*Allowances and denials
**Includes re-adjudicated ("Code 122") cases

Table 11

RETURN RATES FOR MENTAL LISTINGS BY DDS BASIS OF DECISION

ALLOWANCES

Mental Listing Category and Listing Number	Period	Allowances Reviewed	Return Rates			
			All Allowances	Meets	Equals	Medical Vocational
Organic Mental Disorders (12.02)	FY 86	732	3.6	2.0	2.2	10.0
	7-12/86	303	3.6	1.8	5.0	9.2
Schizophrenic, Paranoid and Other Psychotic Disorders (12.03)	FY 86	1,746	2.7	2.4	7.7	3.8
	7-12/86	723	2.1	1.8	0.0	4.4
Affective Disorders (12.04)	FY 86	1,008	6.3	5.4	6.3	8.7
	7-12/86	419	6.2	5.4	0.0	8.9
Mental Retardation and Autism (12.05)	FY 86	2,870	3.4	2.4	10.3	7.8
	7-12/86	1,106	3.5	2.7	9.4	6.6
Anxiety Related Disorders (12.06)	FY 86	191	7.9	8.3	10.0	6.9
	7-12/86	84	8.3	7.0	0.0	10.8
Somatoform Disorders (12.07)	FY 86	56	10.7	9.1	0.0	12.5
	7-12/86	17	17.6	16.7	0.0	20.0
Personality Disorders (12.08)	FY 86	284 —	9.5	11.0	0.0	8.3
	7-12/86	121	7.4	8.9	15.4	4.8
Substance Addiction Disorders (12.09)	FY 86	91	23.1	15.0	14.3	31.8
	7-12/86	47	17.0	12.5	33.3	20.0
Listings 12.02-12.09 Combined	FY 86	6,978	4.6	3.3	8.1	8.7
	7-12/86	2,820	4.2	3.1	6.7	7.9

NOTE: See Appendix for Definitions of Basis Categories

Table 12

RETURN RATES FOR MENTAL LISTINGS BY DDS BASIS OF DECISION

DENIALS

Mental Listing Category and Listing Number	Period	Denials Reviewed	Return Rates					
			All Denials	Not Severe	Can Do Past Work	Can Do Other Work	Durational	Other
Organic Mental Disorders (12.02)	FY 86	120	22.5	16.7	22.9	21.2	14.3	30.8
	7-12/86	76	15.8	0.0	12.5	25.0	8.3	23.5
Schizophrenic, Paranoid and Other Psychotic Disorders (12.03)	FY 86	268	33.6	30.0	28.2	36.5	37.2	35.9
	7-12/86	166	29.5	30.0	30.6	24.3	41.4	19.0
Affective Disorders (12.04)	FY 86	610	18.0	18.1	20.9	20.5	15.9	7.1
	7-12/86	365	14.5	3.7	18.5	17.3	13.9	10.0
Mental Retardation and Autism (12.05)	FY 86	736	15.1	21.2	21.2	17.3	33.3	9.5
	7-12/86	401	12.7	22.2	17.3	14.8	28.6	6.7
Anxiety Related Disorders (12.06)	FY 86	181	13.8	6.3	21.7	11.9	18.2	17.6
	7-12/86	108	13.0	4.2	17.2	11.6	16.7	33.3
Somatoform Disorders (12.07)	FY 86	69	15.9	5.3	20.0	28.6	0.0	0.0
	7-12/86	30	13.3	0.0	15.4	20.0	0.0	0.0
Personality Disorders (12.08)	FY 86	334	10.2	8.5	8.7	10.5	18.2	12.8
	7-12/86	202	10.4	14.3	6.9	12.3	10.0	9.4
Substance Addiction Disorders (12.09)	FY 86	224	17.0	16.3	16.1	23.4	6.7	16.1
	7-12/86	134	11.2	7.1	11.1	13.3	0.0	16.7
Listings 12.02-12.09 Combined	FY 86	2,542	17.0	15.5	18.7	19.1	19.8	12.2
	7-12/86	1,482	14.8	11.7	16.7	15.9	20.6	10.5

NOTE: See Appendix for Definitions of Basis Categories

Table 13

MENTAL ALLOWANCES REVIEWED AND RETURNED BY MAJOR WORKLOAD LISTINGS

	12.02 (Organic)		12.03 Schizophrenic Paranoid)		12.04 (Affective)		12.05 (Retardation Autism)		Other*	
	Cases Reviewed	Return Rate	Cases Reviewed	Return Rate	Cases Reviewed	Return Rate	Cases Reviewed	Return Rate	Cases Reveiwed	Return Rate
National	732	3.6%	1,746	2.7%	1,008	6.3%	2,870	3.4%	677	10.9%
Boston	59	5.1	181	2.8	108	10.2	224	4.5	88	10.2
New York	28	3.6	122	4.1	74	6.8	163	1.8	31	3.2
Philadelphia	91	6.6	199	2.0	107	7.5	342	2.0	61	9.8
Atlanta	116	2.6	249	3.2	125	7.2	509	3.5	51	9.8
Chicago	115	3.5	280	0.7	219	4.1	363	3.3	138	6.5
Dallas	69	0.0	165	4.2	73	4.1	340	4.1	74	13.5
Kansas City	49	0.0	103	0.0	51	5.9	214	2.8	39	12.8
Denver	88	6.8	199	2.0	143	6.3	390	2.6	98	16.3
San Francisco	65	4.6	135	3.7	59	6.8	160	2.5	55	10.9
Seattle	52	0.0	113	6.2	49	6.1	165	9.1	42	16.7

*Includes anxiety, somatoform, personality, substance addition disorders, and listings applicable only to title XVI disabled children.

NOTE: Includes grace period deficiencies

Table 14

MENTAL DENIALS REVIEWED AND RETURNED BY MAJOR LISTINGS
Fiscal Year 1986

	12.02 (Organic)		12.03 (Schizophrenic Paranoid)		12.04 (Affective)		12.05 (Retardation Autism)		Other*	
	Cases Reviewed	Return Rate	Cases Reviewed	Return Rate	Cases Reviewed	Return Rate	Cases Reviewed	Return Rate	Cases Reviewed	Return Rate
National	120	22.5%	268	33.6%	610	18.0%	736	15.1%	888	13.5%
Boston	18	27.8	30	53.3	74	23.0	69	15.9	113	15.9
New York	1	100.0	12	41.7	50	26.0	37	8.1	71	8.5
Philadelphia	25	24.0	43	23.3	59	13.6	78	9.0	93	14.0
Atlanta	16	18.8	41	53.7	91	20.9	121	31.4	92	17.4
Chicago	9	44.4	14	21.4	63	33.3	94	12.8	123	22.0
Dallas	8	25.0	17	17.6	50	6.0	96	9.4	57	3.5
Kansas City	9	0.0	38	15.8	48	8.3	78	9.0	86	7.0
Denver	13	38.5	27	14.8	64	6.3	97	19.6	93	5.4
San Francisco	10	10.0	31	58.1	71	25.4	22	18.2	85	21.2
Seattle	11	0.0	15	20.0	40	7.5	44	2.3	75	12.0

*Includes anxiety, somatoform, personality, substance addition disorders, and listings applicable only to title XVI disabled children.

NOTE: Includes grace period deficiencies

Methodology For Converting FY 1984 and FY 1985 ICD Codes Into Revised Listings Categories

The revised mental impairment Listing categories have been developed on the basis of the diagnostic categories published in 1980 by the American Psychiatric Association in DSM III ("Diagnostic and Statistical Manual of Mental Disorders" — Third Edition). The new Listing categories correspond to similar categories discussed in the DSM III. Chapter 1 of the DSM III (attached), which lists the various categories and enumerates the ICD codes that constitute each classification, served as the authority for most of the conversion of ICD codes to the new Listing categories. Some ICD codes, ones which were not specifically addressed in the DSM III, were assigned to Listing categories on grounds of their classification in the ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification). ICD codes pertaining to "nondependent abuse of drugs", ones which were listed in the DSM both under "Organic Mental Disorders" and Substance Use Disorders", were assigned to the reference Listing of "Substance Addiction Disorders" to gain clearer information on those disorders. The catchall category below of "All Other Mental Disorders" refers to (1) the ICD codes for mental disorders (range 290-319) not clearly belonging to one of the Listing categories and (2) ICD codes that refer to physical disorders but occurred in cases that had been classified as mental impairment cases (body system code of 12) by the reviewing physicians. These were not included in Listings 12.02-12.09 on the tables. Individual sections which follow show differences in ICD-code composition between the Listing categories used in the tables and the corresponding diagnostic categories of the DSM III. Also attached are copies of pages 446-457 of DSM III, which show the ICD-9-CM nomenclature associated with 4-digit ICD codes in the range of 290.0 through 319 (ICD codes on mental disorders.)

Organic Mental Disorders (Listing 12.02)

290.0 - 294.9	Organic psychotic conditions
303.0	Acute alcoholic intoxication
310.0 - 310.9	Specific nonpsychotic mental disorders due to organic brain damage

Variations from DSM III

1. Unlike DSM III, the following ICD codes were included:

290.8
290.9
291.5
291.9

292.2
292.8
292.9
293.1

293.8
293.9
294.9
310.0

310.2
310.8
310.9

2. As mentioned above, ICD codes pertaining to nondependent abuse of drugs were not included under Organic Mental Disorders; they were included in the category of Substance Addiction Disorders. The ICD codes involved were:

305.2
305.3
305.4

305.5
305.6
305.7

305.9

Schizophrenic, Paranoid, and Other Psychotic Disorders (Listing 12.03)

295.0 - 295.9	Schizophrenic disorders
297.0 - 297.9	Paranoid states
298.1 - 298.9	Other nonorganic psychoses, except depressive type psychosis
299.1 - 299.9	Psychoses with origin specific to childhood, except infantile autism

Variations from DSM III

Unlike DSM III, the following ICD codes were included:

295.0	297.0	298.1	299.1
295.5	297.2	298.2	299.8
295.8	297.8	298.4	299.9

Affective Disorders (Listing 12.04)

296.0 - 296.9	Affective psychosis
298.0	Depressive type psychosis
300.4	Neurotic depression
300.5	Neurasthenia
301.1	Affective personality disorder
309.0	Brief depressive reaction
309.1	Prolonged depressive reaction
311	Depressive disorder, not elsewhere classified

Variations from DSM III

Unlike DSM III, the following ICD codes were included:

296.0	296.9	301.1	309.1
296.1	298.0	309.0	311

Mental Retardation and Autism (Listing 12.05)

299.0	Infantile autism
317 - 319	Mental retardation

Anxiety Related Disorders (Listing 12.06)

300.0	Anxiety states
300.2	Phobic disorders
300.3	Obsessive-compulsive disorders
308.3	Other acute reactions to stress (e.g., acute posttraumatic stress disorder)
309.8	Other specific adjustment reactions

Somatoform Disorders (Listing 12.07)

300.1	Hysteria
300.7	Hypochondriasis
300.8	Other neurotic disorders (somatization disorder)
306.0 - 306.9	Physiological malfunction arising from mental factors
307.8	Psychalgia

Variations from DSM III

Unlike DSM III, the following ICD codes were included:

306.0	306.4	306.7
306.1	306.5	306.8
306.2	306.6	306.9
306.3		

Personality Disorders (Listing 12.08)

301.0 - 301.9 except 301.1	Personality disorders, except affective personality disorder

Variations from DSM III

Unlike DSM III, the following were included: 301.3 and 301.9

Substance Addiction Disorders (Listing 12.09)

303.9	Other and unspecified alcohol dependence
304.0 - 304.9	Drug dependence
305.0 - 305.9	Nondependent abuse of drugs

Variations from DSM III

1. Unlike DSM III, the following ICD codes were included: 304.2, 304.5 and 305.8.

2. As mentioned in the explanatory section above, ICD codes pertaining to nondependent abuse of drugs were not included under Organic Mental Disorders; they were all assigned to the category of Substance Addiction Disorders.

All Other Mental Disorders

300.6	Depersonalization syndrome
300.9	Unspecified neurotic disorder
302.0 - 302.9	Sexual deviations and disorders
307.0 - 307.9 except 307.8	Special symptoms or syndromes, not elsewhere classified, except psychalgia
308.0 - 308.9 except 308.3	Acute reaction to stress except "other acute reaction to stress" (except disorders such as acute posttraumatic stress disorder")
309.2 - 309.4 and 309.9	Adjustment reactions
312.0 - 312.9	Disturbance of conduct, not elsewhere classified (e.g., kleptomania)
313.0 - 313.9	Disturbance of emotions specific to childhood and adolescence (e.g., shyness disorder of childhood)
314.0 - 314.9	Hyperkinetic syndrome of childhood (e.g., attention deficit disorder)
315.0 - 315.9	Specific delays in development (e.g., reading disorder)
316	Psychic factors associated with diseases classified elsewhere
001.0 - 289.9 and 320.0 - 999.9	ICD codes pertaining to physical impairments, occurring in cases that review physicians classified as mental impairment cases (body system 12)

Photocopy of Pages 446 - 457 of Diagnostic
and Statistical Manual of Mental Disorders (DSM III)

of specific handicap. The assessment of intellectual level should be based on whatever information is available, including clinical evidence, adaptive behaviour and psychometric findings. The IQ levels given are based on a test with a mean of 100 and a standard deviation of 15—such as the Wechsler scales. They are provided only as a guide and should not be applied rigidly. Mental retardation often involves psychiatric disturbances and may often develop as a result of some physical disease or injury. In these cases, an additional code or codes should be used to identify any associated condition, psychiatric or physical. The Impairment and Handicap codes should also be consulted.

317 Mild mental retardation

Feeble-minded
High-grade defect
Mild mental subnormality
Moron
IQ 50-70

318 Other specific mental retardation

318.0 *Moderate mental retardation*

Imbecile
IQ 35-49
Moderate mental subnormality

318.1 *Severe mental retardation*

IQ 20-34
Severe mental subnormality

318.2 *Profound mental retardation*

Idiocy
IQ under 20
Profound mental subnormality

319 Unspecified mental retardation

Mental deficiency NOS
Mental subnormality NOS

ICD-9-CM CLASSIFICATION OF MENTAL DISORDERS

(without inclusion and exclusion terms)

From The International Classification of Diseases, Clinical Modification, Ninth Revision (ICD-9-CM), Commission on Professional and Hospital Activities, Edwards Bros., Ann Arbor, MI, 1979.

Italics indicate specific ICD-9-CM codes and their categories not included in DSM-III. The lozenge symbol (◊) printed in the left margin preceding the disease code denotes a four-digit rubric unique to ICD-9-CM. The contents of these rubrics in ICD-9-CM are not the same as those in ICD-9.

MENTAL DISORDERS (290-319)

PSYCHOSES (290-299)

ORGANIC PSYCHOTIC CONDITIONS (290-294)

290 Senile and presenile organic psychotic conditions

290.0 Senile dementia, uncomplicated

Explanations of BDS Basis of Decision Categories

Allowances

Meets

Impairment meets level of severity of listing. Regulation (Reg) Basis Codes A1-1520(d), A61-920(d), A61-929, or A61-981

Equals

Impairment equals level of severity of listings. Reg-Basis Codes B1-1520(d), B1-1520(d), A62-920(d), or A62-923

Medical-Vocational

Severe impairment(s) short of severity of listings plus adverse vocational factors Reg-Basis Codes C1-1520(f), or A63-920(f).

Individual with 35-40 years of arduous unskilled work who cannot work at customary level of exertion. Reg-Basis Codes D1-1562, or A64-962.

Denials

Not Severe

Impairment not severe. Denial based on medical considerations alone. Impairment does not significantly limit capacity to perform basic work related functions. Reg-basis Codes F1-1520(c), F2-1520(c), N30-920(c), or N41-920(c).

Can do Past Work

Individual has severe impairment(s) but retains the functional and vocational capacity to engage in SGA in relevant past work. Reg-Basis Codes H1-1520(e), H2-1520(e), N31-920(e) or N42-920(e).

Can Do Other Work

Individual has a severe impairment(s) but retains the functional and vocational capacity to engage in SGA in other than relevant past work. Reg-Basis Codes J1-1520(f), J2-1520(f), N32-920(f) or N43-920(f).

Duration

Impairment prevented SGA for less than 12 months. Reg-Basis Codes E1-1509, E2-1509, N34-909, or N45-909.

Impairment prevented SGA at adjudication but was not expected to prevent SGA (or any gainful activity) for 12 months. Reg-Basis Codes E3-1509, E4-1509, N35-909, N46-909.

APR 05 1981
Initials Date
number.

Other

Engaging in SGA. Reg-Basis Codes N1-1520(b), N2-1520(b), or N44-920(b). Capacity for SGA-vocational considerations (Title II CDB case). Reg-Basis Codes G1-1520(f) or G5-1520(f).

Impairment does not meet or equal Listings (Title XVI Disabled Child case). Reg-Basis Codes N40-923, or N51-923.

Refusal or failure to appear for a consultative examination. Reg-Basis Codes L1-1518, L2-1518, or N37-918.

Failure to cooperate in submitting evidence of disability. Reg-Codes M5-1516, M6-1516, or N36-916.

Claimant does not wish to continue development of claim. Reg-Basis Codes M3-1516, M4-1516, M7-1516, M8-1516, or N38-916.

Failure to follow prescribed treatment. Reg-Basis Codes K1-1530, K2-1530, or N39-930.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

ROBERT SCHISLER, MARY MICELI,
PAULETTE BEARD, FRANK POWROZNIK,
ROSE REESE, HARRY DELANDRO,
MARJORIE HILTS, CINDA COLEMAN,
ROSE MITCHELL and KATHRAN TENNANT,
on behalf of themselves and all
other individuals similarly situated,

Plaintiffs,

-vs-

OTIS R. BOWEN,[1] Secretary of the
United States Department of Health and Human
Services; BARBARA BLUM, as Commissioner
of the New York State Department of
Social Services; SIDNEY HOUBEN, as
Director of the New York State
Department of Social Services
Bureau of Disability Determinations,

Defendants

CIV-80-572E

MEMORANDUM

and

ORDER

The United States Court of Appeals for the Second Circuit has directed this Court to order the Social Security Administration to "state in relevant publications *** that adjudicators at all levels, state and federal, are to apply the treating physician rule of this circuit." Schisler v. Heckler, 787 F.2d 76, 84 (1986). To comply with this mandate, the Secretary of Health and Human Services ("the Secretary") has proposed a rule in the form of a Social Security Ruling ("SSR") which would be applicable nationwide, binding on adjudicators at all levels and available to the public. The Secretary states that he is prepared to issue Program Operations Manual System instructions ("POMS") as soon as the SSR shall have been promulgated.[2]

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[1] The designation of the defendant has been changed pursuant to rule 25(d) of the Federal Rules of Civil Procedure.

This Court has carefully reviewed the proposed SSR and the memorandums of law submitted by the parties and has had the benefit of their oral presentations. It is apparent that the proposed SSR fails to reflect, in significant respects, the treating physician rule recognized and effective here and to be in place nationwide.[3] This Court has therefore edited the proposed SSR to reflect such rule.

Accordingly, it is hereby ORDERED that the statement attached hereto as Exhibit A shall forthwith be issued and published and made effective by the Secretary as an SSR binding upon all adjudicators, both state and federal. It is further ORDERED that the Secretary shall submit to this Court any POMS or other material of explanation or direction which concern the SSR's subject.

Dated: Buffalo, N. Y.
August 5, 1987

John T. Elf
U.S.D.J.

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[2] The plaintiffs assert that SSR's are general expressions of policy which are binding upon all levels within the Social Security Administration. POMS are generally more detailed guidelines used by adjudicators in evaluating claims. See Evelyn v. Schweiker, 685 F.2d 351, 352 fn.5 (9th Cir. 1982).

[3] The SSR proposed by the Secretary is rambling and ambiguous, and not to a small degree unedifying to those in the field who must make the important decisions delegated to the Secretary. There lurks in its lengthy and discursive text bases for not applying the treating physician rule.

EXHIBIT A

Development and Consideration of Medical Evidence

This ruling is purposed at clarifying the policy of the Social Security Administration ("the Administration")[1] on developing medical evidence from treating and other sources and to describe how the Administration evaluates such evidence, including any opinion about disability, in determining whether a claimant is disabled in accordance with the provisions of the Social Security Act ("the Act"). Particularly, this Ruling clarifies when a medical opinion by a treating source will be conclusive as to the medical issues of the nature and severity of an impairment or impairments individually or collectively bearing on the claimant's ability to engage in substantial gainful activity, and indicates how the determination or decision rationale is to reflect the evaluation of evidence from a treating source.

The preferred source of medical evidence which must be reviewed and evaluated in determining a claimant's ability is the claimant's treating source. Medical evidence from a treating source is important because it will provide a medical history of the individual's impairment based on the ongoing treatment and physician-patient relationship with the claimant. In addition to providing medical history, a treating source often provides an opinion about disability. Such opinions are to be carefully considered in evaluating disability. Although the decision whether an individual is disabled under the Act is made by the Secretary, the Administration will consider medical opinions in the context of all the medical and other evidence in making that decision.

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[1] Whatever the shorthand form the Social Security Administration chooses for the purpose of referring to itself will be, of course, satisfactory.

Section 223(d)(5), as amended by the Social Security Disability benefits Reform Act of 1984, requires the Secretary to make every reasonable effort to obtain from the claimant's treating source all medical evidence, including diagnostic tests, needed to properly make a determination regarding disability, prior to evaluating medical evidence obtained from any other source on a consultative basis. A claimant's treating source is his or her own physician, osteopath or psychologist (including an outpatient clinic and health maintenance organization) who has provided the claimant with medical treatment or evaluation and who has or had with the claimant an ongoing treatment and physician-patient relationship, albeit of a short time span and whether commencing before or after the claimant has filed for disability benefits.

Medical evidence and opinion from a claimant's treating source is important because the treating source on the basis of the ongoing physician-patient relationship is most able to give a detailed history and diagnosis and a reliable prognosis. Therefore, treating source evidence and opinion should always be requested and every reasonable effort should be made to obtain it. The treating source should be requested to provide complete medical reports consisting of a medical history, clinical findings, laboratory findings, diagnosis, treatment prescribed and the response thereto, prognosis, and a medical assessment -- i.e., a statement of the individual's ability to do work-related activities. If the treating source provides an incomplete medical report, the Administration will request the necessary additional information from the treating source. Where the Administration finds that the opinion of a treating source regarding medical issues is inconsistent with other evidence in file, including opinions of other sources which are supported by medically acceptable clinical and/or laboratory diagnostic techniques, the Administration must resolve the inconsistency, according to the principles set forth below. If necessary to resolve the inconsistency, the Administration will secure additional evidence and interpretation or explanation from the treating source and/or consulting sources.

Once the adjudicator has made every reasonable effort to obtain the medical evidence and to resolve all conflicts, the adjudicator must evaluate all of the evidence in file in arriving at a determination. Initially, the adjudicator must review the record to determine what is the treating source's determination concerning the claimant's disability. The adjudicator should then examine the record for conflicting evidence. Upon finding conflicting evidence, the adjudicator should compare the probative value of the treating source's opinion with the probative value of the conflicting evidence.

The treating source's opinion on the subject of medical disability -- i.e., diagnosis and nature and degree of impairment -- is (1) binding on the fact-finder unless contradicted by substantial evidence and (2) entitled to some extra weight, even if contradicted by substantial evidence, because the treating source is inherently more familiar with a claimant's medical condition than are other sources. Resolution of genuine conflicts between the opinion of the treating source, with its extra weight, and any substantial evidence to the contrary remains the responsibility of the fact-finder.

Substantial evidence is such relevant evidence as a reasonable mind would accept as adequate to support a conclusion. The opinions of non-examining medical personnel cannot, in themselves and in most situations, constitute substantial evidence to override the opinion of a treating source.

Where the opinion of a treating source is being rejected or overridden there must be a discussion documented in the file of the opinion and medical findings provided by the medical sources, an explanation of how the Administration has evaluated the reports, a description of any unsuccessful efforts to obtain information from a source or sources, the pertinent nonmedical findings, and an explanation as to why the substantial medical evidence of record contradicts the opinion of a treating source. This discussion must be set out in the rationale of a determination or decision.

Chairman **Jacobs**. Thank you. Ms. Shor.

STATEMENT OF NANCY G. SHOR, EXECUTIVE DIRECTOR, NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES

Ms. **Shor**. Thank you.

My name is Nancy Shor and I am from the National Organization of Social Security Claimants' Representatives.

I appreciate very much the opportunity to testify before you today. I want to commend both the members of the subcommittee and the staff for the consideration you have shown to a very pesky and persistent problem, that is, attorney's fees in Social Security cases.

As I indicated to you in my testimony last May, we are in a serious situation. Changes are badly needed in the system that currently regulates fees. In that testimony, I stated that a March 31, 1987, memorandum reducing the authority of ALJs to set fees from $3,000 down to $1,500 would have a drastic impact on the ability of claimants to retain counsel and the ability of attorneys to continue to represent them.

I want to report to you today, 5 months later, our fears have been realized. Many of our private attorneys have advised me that they are no longer accepting any new Social Security claimants, regardless of the merits of their cases.

Unless the package already approved by this subcommittee is enacted, I do not see anything that is going to change this trend. This set of reforms is a reasonable and sound approach to the subject and reflects a careful balancing of interests. Its enactment will ensure that a pool of qualified and competent counsel will be available for disabled claimants who want representation.

I have had an opportunity to review a lengthy set of proposed regulations from the Office of Hearings and Appeals. If these new regulations are implemented, claimants will be hard pressed indeed to find any private attorneys to represent them on anything other than a pro-bono basis.

The new system proposal suggests a plan completely unmanageable and completely unworkable.

I am delighted to see the written testimony this morning furnished by Associate Commissioner Bradley from OHA, indicating that these proposed regulations will not be published in the Federal Register until Congress has had an opportunity to consider the attorney fee package that this subcommittee has already approved.

I am delighted to learn this morning that previously stated plans to publish the proposed regulations by late summer have been abandoned. As a result, you will be delighted, no doubt, that I will forego much of my prepared statement.

As a result of the testimony and proposals from a variety of commentators this spring, this subcommittee has already drafted and endorsed a simplified and fair fee system, which responds to the criticisms of the present system. Its enactment will mean that attorneys who have left this practice may return, that attorneys who were planning to phase out their Social Security practices may yet change their minds.

My conversations and correspondence with members of our organization has substantiated the concerns about which I testified before you last May. As I predicted, we are experiencing major reductions in fees, major increases in delays of fee approvals, and a considerable decrease in the number of attorneys who will represent Social Security claimants.

I simply want to commend this subcommittee for its work on the issue, and applaud your endorsement of this reasonable fee system. I can only assure you today that its enactment is crucial if claimant's rights to representation are to be meaningful rights.

Thank you for permitting me to testify today.

[The statement of Ms. Shor follows:]

Testimony of
Nancy G. Shor,
Executive Director

National Organization of
Social Security Claimants' Representatives

19 E. Central Avenue
Pearl River, NY 10965
(914) 735-8812

Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to appear before you today. I want to commend you and your staff for the consideration you have shown and the legislation that this Subcommittee, and the full Committee as well, have approved concerning the regulation of attorneys' fees in Social Security cases. As I indicated in my testimony before you on May 13, changes are needed in the system which regulates fees. In that testimony, I stated that a March 31, 1987 memorandum reducing the authority of Administrative Law Judges to set fees from $3,000 to $1,500 would have a drastic impact on the ability of attorneys to continue to represent Social Security claimants. I can report to you today, five months later, that our fears have been realized. Many private attorneys have advised me that they will no longer accept any new Social Security claimants. Unless the package already approved by this Subcommittee is enacted, I see nothing that will reverse this trend.

Your set of reforms represents a reasonable, and sound approach to the subject, and reflects a careful balancing of interests. Its enactment will ensure that a pool of qualified and competent counsel will be available for those disabled claimants who want representation. Its enactment will ensure that the statement, "You have a right to be represented," is not a hollow promise, but is in fact a meaningful right.

I have had an opportunity to review a lengthy set of proposed regulations prepared by the Office of Hearings and Appeals. If these new plans for regulation of attorneys' fees in Social Security cases are implemented, claimants will be hard-pressed indeed to find attorneys who are willing to represent them. This new system governing the authorization of attorneys' fees is so unmanageable and unworkable as to effectively drive many attorneys away from this area of practice.

The OHA draft presents a major change in the attorneys' fees system, a change towards more regulation, more paperwork and more complexity. My review of these proposed regulations suggest that they are completely at odds with the approach taken by this Subcommittee.

The draft set of proposed regulations is seriously flawed in several respects:

(1) It establishes a whole new level of bureaucracy involving non-lawyers who are called upon to judge the quality of an attorney's representation without even having the opportunity to review the file, much less observe the quality of the attorney's representation in person.

(2) The regulations establish an hourly rate of compensation which does not give any consideration to the risks undertaken by the attorney in connection with his representation. Out of necessity, almost all of these cases are taken on a contingent fee basis. The attorney gets paid only if he is successful in winning the case. For the vast majority of claimants, they are unable to enter into any type of fee arrangement other than contingent. To ignore this is to ignore reality.

(3) The Social Security Administration proposes to use "standard time ranges" in determining whether the amount of time devoted to the case by the attorney was "reasonable". It is rumored that the Social Security Administration will consider approximately eleven (11) hours per case to be a "standard time range." The proposal states that neither the representative nor the adjudicator will know the standard time value, but that there will be no compensation for reported time which exceeds the "established parameters."

Our members typically spend a substantial amount of time with clients, in case preparation and development, with case presentation at the administrative hearing, and often in post-hearing development. They spend countless hours following up favorable decisions with the SSA bureaucracy to see that their clients are paid. I shudder to think that an agency bureaucrat will simply ignore the time that attorneys devote to these activities simply because they do not fit within an "agency guideline." Attorneys must respond to the needs of their clients as they exist and develop in individual cases.

(4) Finally, the proposed agency hourly rates of compensation seem unreasonably low. Although the agency makes an effort to adjust the hourly rates based upon geographical considerations, they do not seem to offer any rationale that their base rate of approximately $63 per hour is reasonable. If reasonably competent attorneys are going to practice in this area of the law, it would appear that the rate of hourly compensation should reflect prevailing market rates. One of the most authoritative measures of prevailing market rates is the Annual Survey of Law Firm Economics prepared by Altman & Weil, Inc. The 1986 survey showed that for a partner in a law firm with ten years experience the middle range of hourly billing rates was $90 to $126 per hour. Additionally, the survey showed that the average overhead was 43.3% of annual billings and that the average annual billable hours was 1,644 hours per year.

The current fee system can and should be improved. But this new proposal devises a system that is, in virtually every way, worse than the present system. It is complex, labor-intensive, time-consuming, and will not produce fair compensation.

As one of our members stated in a recent letter to his Congressman, "The fact is, legal representation in Social Security cases means that claimants are far more likely to ultimately obtain benefits because skilled attorneys are able to gather, present, and effectively argue medical and vocational evidence in a particular case. The agency is attempting to drive qualified and experienced practitioners away from the field of Social Security representation in order to assure that the 'bureaucracy' instead of the 'law' is the last word."

As a result of testimony and proposals from a variety of commentators, this Subcommittee has already drafted and endorsed a simplified and fair fee system which responds to the criticism of the present system. This draft regulatory plan heads, catastrophically, in exactly the oppcsite direction. Its implemention will drive attorneys from this practice, leaving claimants unrepresented in their struggles to establish their right to disability benefits. Many of these severely physically and mentally impaired claimants are completely unable to represent themselves. SSA's own statistics, that 66% of represented claimants win at the hearing level in contrast to 36% of unrepresented claimants, foretell what the long-range impact of these proposed regulations will be.

Thank you for your attention. I would be pleased to respond to any questions or comments.

Chairman JACOBS. Thank you for your contribution.
Mr. Weisberg.

STATEMENT OF CLIFFORD L. WEISBERG, ESQ., SOUTHFIELD, MICHIGAN

Mr. WEISBERG. Mr. Chairman, my name is Clifford Weisberg. I am a private attorney who specializes in Social Security law. That is my exclusive practice.

For the sake of brevity, I can simply echo the words of Ms. Shor concerning the work of the subcommittee. I commend the subcommittee for an excellent plan which, I believe, encourage many of my brothers and sister attorneys to return to the field of Social Security law.

I think a significant fact that the Secretary has never recognized is that legal services to a claimant do not end with a favorable decision. Numerous problems with beneficiary development, representative payee issues, benefit computation, Medicare coverages, insurance coordination problems, worker's compensation offset, all occur after the favorable decision.

With the staff cuts already testified to this morning, at the district offices, they are hard pressed to handle all these problems and often those claimants must turn to the representative to assist in having these issues solved.

Though I cannot speak for all of the attorneys in my area that specialize in this field, I would estimate that we average not less than 30 phone calls per week from senior citizens, clergy, congressional staff members, charitable organizations, and most importantly, other attorneys asking for help with their Social Security questions.

Over the years, I have found it very difficult to generate interest among young lawyers to learn Social Security law. Social Security practice can be the most rewarding experiences one can encounter in their professional career. Yet, bright law students who clerk in our offices during their law school training cannot ignore how these fee issues have impacted on those of us who have specialized in this field over the years.

The provision of the committee's plan accomplishes a fair, easily implemented system for attorney compensation. It will foster increased willingness by a larger number of competent attorneys to handle Social Security claims.

The complexity of the act that has developed over the years is easily appreciated by noting that 14 years ago the only resource material aside from the statute itself, was a one volume treatise by an administrative law judge. Currently, there are over 20 different library services and publications on Social Security and Social Security related topics. It requires not less than 3 hours per week, on the average, to keep familiar with all the changes implemented by the administration and the case law handed down by the courts.

Again, I wish to express my sincere appreciation to the subcommittee for being so sensitive to this issue and I ask and hope that the attorney fee plan authored by this subcommittee will be implemented as soon as possible.

Thank you.

[The statement of Mr. Weisberg follows:]

SUBCOMMITTEE ON SOCIAL SECURITY # 7
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
HEARING OCTOBER 6, 1987, ROOM B-318, RAYBURN HOUSE OFFICE BLDG.

STATEMENT OF
CLIFFORD L. WEISBERG

Thank you Mr. Chairman and members of the Committee for allowing me to testify. I was most encouraged by the far reaching legislation authored by the Committee and believe it will solve most if not all of the major problems with attorney compensation in Social Security cases. If this Bill is adopted and signed into law, it will, for the first time in at least the 18 years I have been practicing before the Administration, give the practitioner and claimant a clear, concise and predictable formula for setting the attorney's compensation. Counsel will be allowed the luxury of knowing in advance that the fee agreement between himself and his client will be honored.

There is no question that fee abuses do occur. But I would submit that they are few and far between. I base this belief on the report furnished by the Secretary indicating that a relatively small number of fee complaints have been filed by Claimants. The most recent number reported totaled 347 complaints out of a possible 65,000 petitions filed. Those cases where there have been abuses, though few in number, have caused what I term an over-reaction by the Social Security Administration to the fee setting process. Initially, the Secretary relied heavily upon a report of the Inspector General indicating that a fee rate of no more than $ 75.00 is reasonable. How this rate was chosen I have no idea. Absolutely no input from either disabled claimants or from those of us who handle these cases on a daily basis was obtained by the author of this report. Reading the report leaves the impression that the attorney is paid whether he wins the claim or not. Certainly this is not the case. Our office handles between 100 and 150 cases per year. We win, on the average, 80%. We spend an average of $ 250.00 per case which, due to the economic condition of the claimant, is rarely if ever reimbursed should the claim be lost. If a case must be filed in U.S. District Court, filing fees of $ 120 must be paid along with the costs for certified postage. The average number of hours of work, excluding cases that reach the Courts, is 15.5 hours per case. This means that in a 100 case year where 20% are lost, a total of 310 hours of work will be uncompensated. In addition, costs in these lost cases would average an aggregate total of $ 5,000 for which again the chance of reimbursement would be remote. After deducting the amount of uncompensated hours plus unreimbursed costs from the amount of the cases won, the net for handling these 100 cases would result in an hourly rate of $ 41.77. It costs over $ 50.00 per hour to keep our doors open! If adopted there would be no way we could continue to handle Social Security claims. It should also be pointed out that the time necessary for preparing the fee petition and the time frame for receiving actual payment was not even considered by the IG. Once a fee is authorized, it usually takes an additional 45-60 days for payment to arrive.

As indicated, my perspective comes from specializing in Social Security for over 18 years, the last 5 of which have been devoted exclusively to this field. I often encounter incredulous expressions from not only lay people inquiring in what fields of law I practice, but also from other practicing attorneys. Their puzzlement is usually followed by the recurrent question as to just how do you make a living doing this kind of work? Unfortunately, that attitude has not changed very much over the years. It is an attitude fostered by the ever constant bureaucratic change in interpretation and policy for which the Administration is well known. I will discuss this a bit later, but initially I would like to express my concerns about the Secretary's methods in first identifying the problems with setting attorney fees in these cases, and secondly with the Secretary's suggestions for implementing new fee setting procedures.

On March 31, 1987, the Secretary announced that the adjudicator hearing social security claims will no longer be allowed to authorize fees in excess of $ 1,500. Up to that point, the adjudicator, usually an administrative law judge, could authorize up to $ 3,000. The change was prompted by the Inspector General's report referred to above challenging the amounts attorneys were charging and receiving in these cases. This report was badly flawed for the reason that no input was ever obtained from claimants who had actually gone through the appeal process nor from attorneys handling these cases. The Secretary compounded the problem by implementing the above changes again without getting detailed information from either those who have gone through the process, or from representatives who practice in the forum.

Since implementation, the $ 75.00 hourly rate has been implicitly followed. Though it is true that the representative could appeal to the Chief ALJ in his region for a larger fee, the time frame for processing the review hardly makes it worthwhile to do so. The policy in our office has been to forego any appeal if the amount is within $ 1,000 of the limit. Unfortunately, the hourly rate we are averaging since this March 31st change has been reduced almost 30%. Obviously, it would no longer be profitable for this firm to handle social security claims.

The history of the disability program shows a clear Congressional intent to encourage attorney representation. The use of contingent fee contracts is the standard method most attorneys utilize in accepting these cases. A small but highly skilled group of attorneys has developed over the years willing to accept the challenge of learning Social Security Law and keeping abreast of the constantly changing Act. Changes in rulings, regulations, statutes and case law, as well as the Secretary's frequent policy and procedure transmittals have required dedicated study and vigilance. To my knowledge, those attorneys who have made the effort over the years number less than 15 in the Detroit tri-county area. Indeed, the number has been further reduced as a result of the Secretary's March 31st changes. I would suggest that unless the Committee's legislation is adopted and becomes law, few, if any private counsel will handle these claims. One can only speculate on the competency level of those who do continue to practice in the field. Based on our experience, an immeasurable number of hours are needed to keep informed on the administrative and legal modifications as well as the constant changes in medical diagnoses and treatment. It is easy to forsee a potentional crisis developing for those disabled seeking help with their claims. Legal aid facilities who have already suffered significant staff cuts will not be able to handle the increased volume of cases. Furthermore, there would be limited funds available to do the necessary development that most cases require. It will also result in an undo burden on the many Congressional staffs to whom claimants will turn for assistance thinking that a simple letter or phone call from one's Senator or Representative will persuade Social Security to award benefits.

A significant fact that the Secretary has never recognized is that legal services to a claimant do not end with the favorable decision. Numerous problems with beneficiary development, representative payee issues, benefit computations, medicare coverages, insurance coordination problems, workers' compensation offset, all occur AFTER the favorable decision. This time is rarely, if ever, compensated and is viewed by the practitioner as being part of the orignal contingent fee contract for services. However, if the Secretary's proposal takes effect, the disabled individual will have no one to turn to for these post-hearing problems. Though I can't speak for all of the 15 specialized attorneys in my home area, I would estimate that we average not less than 30 phone calls per week from senior citizens, clergy, Congressional staff members, charitable organizations, and most importantly, other attorneys asking for help with Social Security. The practitioner is confronted with problems and questions not only on disability, but also on survivorship, medicare, retirement, and spousal rights under the Act. People with questions that cannot be answered are referred to the proper office or information source.

As indicated above, the most important piece of data missing from the IG's report and the Secretary's rationale for changes in the fee setting process, is input from the claimant. I, for one, would be most interested in knowing the current number of complaints that have been filed by disgruntled claimants dissatisfied with the fees their attorneys wish to charge. Have claimants or organizations of people who have gone through the social security system voiced protests with the contingency fee arrangements that have been used over the years? Have Congressional staffs been contacted with citizens upset with how their attorneys were paid in their social security cases? In the 18 years I have practiced social security law, during which I have handled somewhere between 2000 and 3000 claims, I have had one fee complaint filed by a client.

The provisions of the Committee's bill accomplishes a fair and easily implemented system for attorney compensation. It will foster increased willingness by a larger number of competent attorneys to handle social security claims. The complexity of the Act that has developed over the years is easily appreciated by noting that 14 years ago the only resource material aside from the Statute itself, was a one volume treatise by an Administrative Law Judge. Currently, there are over 20 different library services and publications on social security and social security related topics. It requires not less than three hours per week, on the average, to keep familiar with all the changes implemented by the Administration and the case law handed down by the Courts.

After announcement of the Committee bill, we have learned that the Secretary has prepared a 121 page interim proposed regulation on fee authorization utilizing a new "lodestar" approach. It assumes a presumptive number of hours needed to handle the "typical" disability claim. The lodestar hourly rate for Michigan for an attorney who handles more than 100 cases per year would be $ 81 per hour. If adopted, I don't think it would be too hard to figure that our office could no longer accept social security cases. Aside from barely breaking even assuming we could be very selective in the cases we handled and possibly increase our success rate to 90%, we would nevertheless have no way of providing the additional post-decision services that are required in the majority of cases. The claimant would have to handle these matters on his own. More importantly, the proposed regulation defies explanation. How is one to encompass its language in a fee agreement that is understandable to a claimant? Services would have to be tailored to the predetermined number of hours implicit in the regulation.

Over the years I have found it very difficult to generate interest among young lawyers to learn social security law. The pre-conceived notions described above do not fall easily. Yet, Social Security practice can be among the most rewarding experiences one could encounter. Bright law students who clerk in our office during their law school training, can't ignore how these fee issues have impacted on those of us who have specialized in this field over the years. As a result, they are totally turned off to the specialty. In our state, though we have over 25,000 lawyers licensed to practice, there is a major shortage of attorneys competent to handle social security claims. I have canvassed staff attorneys and administrative law judges of several offices of hearings and appeals. They confirm the chronic shortage of competent people capable of handling these cases. The Secretay's proposed Regulation would have a chilling effect by causing a further erosion in the already meager number of knowledgable counsel.

Our experience has shown that most claimants are not just interested in the monthly benefits they and their dependents receive, but more importantly, are looking to regain a level of dignity and self respect. Anyone who files for disability quickly learns how overbearing and intimidating the process can be. A denial can have devastating effects on one's pride. In the vast majority of cases, an award of benefits restores a certain level of self-respect and self-worth. Helping reclaim that feeling of dignity to a disabled person brings a professional satisfaction that cannot be measured or described. I truly think that is why we are fighting so hard to have the Committee's Bill adopted. I can only hope that I have been able to adequately convey a true picture of the present crisis and generate as much support as possible for the Commitee's farsighted legislation. Thank you for your interest and concern for the disabled.

Respectfully submitted,

Clifford L. Weisberg

Chairman **Jacobs**. Thank you, Mr. Weisberg.

Mr. Levin will inquire.

Mr. **Levin**. Thank you very much, Mr. Chairman and thank you for moving ahead with this hearing.

I understand that Pat Dilley is leaving us.

Chairman **Jacobs**. All I can say is she is wearing yellow, so she must be chickening out. [Laughter.]

Mr. **Levin**. I think you just laid an egg. [Laughter.]

We will miss you.

I want to say a special hello, well to everybody, and a special, special one to Cliff Weisberg. It turned out, I did not remember, that we once knew each other. He has twin brothers. He mentioned that he used to watch while the older kids played basketball back in Michigan. I am still older.

Mr. **Weisberg**. You never let me play.

Mr. **Levin**. I was at the last hearing and never could quite figure out why there is so much of a gap on this issue of representation, where people were really coming from, what was motivating the Social Security Administration, which is supposedly looking out after the interest of claimants.

Maybe they think they are, and maybe they are, but let me just ask you, in terms of facts, what has happened since the new regulations? What is going on in the field?

I think that maybe is more important than theory.

Mr. **Weisberg**. Congressman, I can say this much, from my own personal knowledge, I estimate there are no more than 15 attorneys who really specialize in the field of Social Security law in the Detroit metropolitan area. I believe we are talking about an area somewhere between 6 and 7 million people.

Of those 15, 4 work for firms and they have now been told that they will no longer be able to accept Social Security claims, period, because of the fee problems, in terms of limiting the fee authorization to $1,500. With the appeal process, it just does not make it worthwhile or profitable, for that matter, to take an appeal if more than $1,500 is being sought, under this interim policy of the Secretary.

That is very frightening.

The other thing is when you do accept a case, you accept representation, it is almost like being a little bit pregnant. Once you are in, you are in; 99 percent of these cases, if they are not won at the hearing level, are going to go into Federal court. And if you are going to go into Federal court, you are talking about some dollars and cents that can mount up very quickly, aside from the development of the claim itself.

Filing fees have just been increased to $120. A lot of claimants do not meet the forma pauperis requirements of our courts and they just do not have that kind of money.

These are the kinds of costs you are going to have to advance. You are going to have to advance these costs if you are really going to do your job. So what happens is, when you have a claim that comes in, you are going to have to make a decision during that first interview. You are going to have to decide whether you are going to commit to that case or not.

Because of the Secretary's recent fee policies, we are flinching. The bottom line is we are flinching. That is what it has come down to. It is wrong and I can only tell you, that cases we would accept, on contingency a year ago or even 6 or 8 months ago, we just cannot afford to accept now.

So I would say the volume of cases coming into our office has been reduced at least a third.

To better demonstrate this fact simply contact our two offices of hearings and appeals, the one in Detroit and the one in Oak Park. They are 17 miles apart. The judges have literally nothing to do. The cases are not getting there anymore.

What is happening, instead of handling cases on a local basis since the volume—at one time we were probably No. 3 or No. 4 in the United States on a per capita basis. They are sending our judges all over the country to help out in other regions.

I think if you combine those facts, you can see what kind of an effect it is having. It is having an effect on the number of claims getting into the system itself and eventually it is going to affect the claimants by discouraging even them from seeking representation. I think this is a chilling fact.

Mr. **Levin**. Anybody else? Yes, Mr. Maxwell.

Mr. **Maxwell**. I would like to cite some figures to you, sir. Federal payments to DDS's increased from $666 million in fiscal year 1985 to $755 million in 1986. In 1987, the budget was decreased to $741 million, and it is anticipated it will be about the same in 1988.

And yet we are having all of these reconsiderations coming into the system. We are having an increased load as the population is aging, and as a consequence, the workload is higher. And the determination that the caseload should be 195 instead of 165 is just out of sync with reality. And so that I feel that—is it budget pressure, fiscal responsibility pressure is really impeding, I would say, the human application of the system.

Ms. **Sweeney**. I would just like to add something to what Cliff said. And that is that what we are starting to see, which has always been a problem but it is getting worse, is that SSA tells the person, you can appeal or you can file another application. And so you get these people who keep repeating through the first two levels of the system and they are constantly denied. They do not get representation. They cannot get to the ALJ stage.

And then eventually their insured status expires while they have been going through this. And also, every time they do this they are told, the decision from last time is res judicata because you did not appeal it. And then the attorney has to step in and try and figure out how to undo four or five of these applications that should never have been filed to get back to the first one to get him his insured status back.

And the result is, you have a much more complicated case for the attorney and for SSA than if the person had been able to get an attorney in the first place and get to the ALJ stage and get their benefits. Not to mention the fact that the person has been without benefits now for years before they ultimately prevail.

Mr. **Levin**. Is this isolated?

Ms. **Sweeney**. No, sir. SSA is doing this right now. And anytime a person is undergoing a continuing disability review in their case

SSA—when they go in, SSA says, now do not forget you can always file a new application. They should file a new application, but they do not want to give up on the old one because that is what protects their insured status for most of these people. And also, they have the res judicata problems of having a prior bad decision against them on the medical condition.

Mr. **Levin**. They have not explained that?

Ms. **Sweeney**. No. They do not have the staff to explain information like that.

Mr. **Levin**. SSA is saying, refile even though they are going to raise res judicata?

Ms. **Sweeney**. Right. I mean, it is different people in the local office, but it regularly happens. And if you are faced with the idea of going and finding an attorney or just reapplying, it sounds like a good deal. First, you lose all the money, but you also have this problem that they are not going to find you eligible on the new application.

It is an easy out for the administration, just file a new application. And it is a very serious problem. We are seeing many of these cases. People go into the office. You say, "why did you not appeal the last time?" And they say "they told me I could just file a new application." It is a regular pattern that is developing and it is going to get worse now with the attorney representation problems.

Mr. **Weisberg**. If I may add just one thing, Congressman. I believe that according to the last statistics I am familiar with, there are about 1 million claims filed a year. Less than 20 percent are paid at either the first or second step of the appeal process. Once you get beyond the second appeal level, comes the third step, the hearing step, your chance of getting your claim paid jumps to over 50 percent.

However, of the 800,000 that are denied at either the first or second level, only 300,000 end up in the Office of Hearings and Appeals. They just fall right out of the system.

Mr. **Levin**. Of course, I suppose SSA would argue that those who appeal are the ones who have merit, and we would have to take a look at that argument. I am sure they would raise that, that it is a self-selection process.

I think it would be useful, Mr. Chairman, if you would, to the extent you can do so ethically—you may have to get approval from people—but it would be interesting for us to have instances of where people are told to reapply, and not informed of the impact of not appealing.

It seems to me there is surely one obligation of Government, and that is to make sure people understand their rights. And to half inform people is to misinform. It would be interesting—it would be useful if we had concrete evidence.

Mr. **Weisberg**. One other thing, it is not unusual for someone to go into one district office, go into another district office, go into a third district office and be given three different pieces of advice. That is very common.

Ms. **Sweeney**. I would be very happy to ask—I am a legal services attorney and work with a network of legal service attorneys on these issues. And I would be happy to ask them—as a practical matter, because we are legal service attorneys, I would need a request from you or from Mr. Jacobs to even ask them to send you that information because of the restrictions that legal service attorneys are under.

But if I could get a request like that, I would be happy to send that to them, and they could respond to you.

Mr. **Levin**. I think that would be the chairman's prerogative.

Chairman **Jacobs**. I think we particularly would welcome the exact information—as Mr. Levin says, your client-attorney relationship may preclude certain kinds of information. But the more specific you can get, the better off we will be. Generalities come cheap.

Mr. **Levin**. So maybe a request, a more formal request should be sent. Maybe that could be worked on.

Chairman **Jacobs**. Yes, I suspect there may be some contrast between the two.

Mr. **Levin**. Thank you very much.

Chairman **Jacobs**. Thank you, and we thank the panel for your contribution.

The next panel is the Michigan Department of Education, Disability Determination Service, Dr. Ivan Cotman; Massachusetts Disability Determination Services, Philip Johnston. Please come forward and present your testimony in your own manner and in the order in which you were called, remembering the 5-minute rule.

STATEMENT OF IVAN LOUIS COTMAN, ASSOCIATE SUPERINTENDENT FOR REHABILITATION AND DISABILITY DETERMINATION, MICHIGAN DEPARTMENT OF EDUCATION; ALSO ON BEHALF OF MARTHA MARSHALL, MICHIGAN DISABILITY EXAMINER, AND VICE PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

Mr. **Cotman**. Thank you, Mr. Chairman and members of the committee. I am Ivan Louis Cotman, associate superintendent for rehabilitation and disability determination in the Michigan Department of Education. In this capacity, I am responsible for the Michigan Disability Determination Service and the Michigan Rehabilitation Service. DDS, as you know, is the State agency which will process over 95,000 disability claims, including continuing disability reviews this year.

I am pleased to make this joint presentation to you on behalf of the State department of education and a disability examiner with 15 years of experience, who also serves as the Midwest vice president of the National Association of Disability Examiners. She is Martha Marshall, who regrettably could not accompany me today. Because of her responsibilities, she is attending the national meeting of the disability examiners in Portland.

But this highlights, we feel, the importance of this employees taking time now to provide necessary coalitions to preserve the integrity of her position through the National Association of Disability Examiners, protect jobs, and to serve disabled people. Years ago that would not have been necessary.

We both feel strongly about the cutbacks taking place within the Social Security Administration and their impact upon American disability applicants and beneficiaries for whom the program was designed.

With respect to the issue of federalization, we do not believe that that is the answer, as was raised by Congressman Archer. But we believe, instead that a more humane, more efficient response to the State disability agencies is the alternative of choice.

My remarks and those of Ms. Marshall have been provided in advance and I would like to submit them for the record, and briefly in the remaining time highlight some special problems we face in Michigan that speak to the need for continued oversight by Congress of the Social Security Administration.

First, let me just tell you that the relationship between the state agency and the disability Social Security Administration is strained, suspicious and tense. We are precluded, almost frowned on in terms of making our message known to the media and to Congress. There is a need for continuing monitoring. And let me just share with you some of the problems that we face with respect to being able to do our job and support in terms of additional funding.

SSA in 1984 provided us with 568 full time equivalent positions. In 1985 that was increased to 571. In 1986 it was increased to 586, which they said was in anticipation of the continuing disability reviews. Those 4,000 cases never materialized. The fact that there was an increase in a number of cases reviewed under the continuing disability act led Hon. Governor James Blanchard to institute an executive order directing the disability agency in Michigan to cease and desist from processing to completion continuing disability reviews.

Thereupon, the SSA the very next year directed the DDS to drop its staff from 586 to approximately 520 full time equivalent positions. Over the last year we have had continued disruptions with our staff which has been decreased by 103 positions, with the threat of possible layoffs through SSA cutbacks in funding, including the threat of possible closure of offices.

And only through the good graces, and support of the superintendent of the state board of education have we taken steps, to place those 103 persons in positions outside of the DDS through transfer and attrition, and in some cases options by the individual to retire. We have not fallen prey to the pressures we had upon us to layoff and close offices.

I think you can recognize, Mr. Chairman, and members of the committee, having staff of your own, how disruptive it would be to your staff to face the threat of losing a job heretofore funded 100 percent federally through sudden funding cutbacks. And our staff in Traver City, Lansing, Kalamozoo, and Detroit, have all been frightened about the prospect of losing their jobs through this dramatic fear inducing cutback in Social Security funds, without the necessary time to put in place programs that would allow us to continue to serve the people of Michigan and reduce our program and staff in a nonthreatening and nonlayoff oriented manner.

So I say in short, that we believe that the SSA push for higher productivity should cease. The DDS must have more time to plan its budget and that the Social Security regional offices should have greater freedom and flexibility to authorize DDS funding.

And lastly, we believe that a hearing such as this which provides an opportunity to present our view to the media and to Congress should be maintained. Further, the congressional oversight capacity should be a major part of the vigilance that is put in place routinely to assure that Social Security beneficiaries are served through preservation of jobs and maintenance of support for disability agencies through assured SSA funding.

We appreciate the opportunity to bring these views to you on behalf of Ms. Martha Marshall and myself.

[The prepared statement follows:]

STATEMENT
OF
DR. IVAN LOUIS COTMAN
ASSOCIATE SUPERINTENDENT FOR
REHABILITATION AND DISABILITY DETERMINATION
MICHIGAN DEPARTMENT OF EDUCATION
AND
MS. MARTHA MARSHALL
MICHIGAN DISABILITY EXAMINER
AND
VICE PRESIDENT
NATIONAL ASSOCIATION OF DISABILITY EXAMINERS
BEFORE THE
HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON SOCIAL SECURITY

CHAIRMAN
THE HONORABLE ANDY JACOBS, JR.

October 6, 1987

INTRODUCTORY STATEMENT

Chairman Jacobs and members of the House Ways and Means Subcommittee on Social Security, I am Ivan Louis Cotman, Associate Superintendent for Rehabilitation and Disability Determination in the Michigan Department of Education.

In this capacity, I am responsible for the Michigan Disability Determination Service (DDS), the state disability adjudication agency, which this year will process over 95,000 Michigan disability claims including the assessment of continuing disability reviews.

I am pleased to make this joint presentation to you on behalf of the State Board of Education. My presentation also represents the views of a key member of the Michigan DDS examiner staff with over 15 years of experience, and who also serves as the Midwest Vice President of the National Association of Disability Examiners. She is Ms. Martha Marshall. I regret she could not accompany me today. Because of her responsibilities as an officer of the National Association of Disability Examiners, she found it necessary to be in Portland, Oregon, for their national meeting. I would suggest that her need to be at that meeting speaks to the situation this program and the employees who serve us in carrying it out are facing. Like never before, they are compelled to network and build a coalition to preserve the integrity of their program.

We both feel strongly about the cutbacks taking place within Social Security and their impact on American disability applicants and beneficiaries the program was designed to serve.

BACKGROUND INFORMATION

In our respective state and national roles, Ms. Marshall and I recognize the problems caused by the federal deficit and the resultant need to effectively manage public funds. Some cutbacks in federal programs are necessary, but I would suggest they should be accomplished in the fairest method possible without overly damaging any particular sector of the population, especially our most vulnerable. However, we strongly feel that we are standing at the brink of the precipice between necessary cutbacks and significantly reduced services that will harm the very people we serve, disabled Americans. The continuing trend of reduced Social Security Administration budgets, reduced staffing and ever-increasing productivity targets will also ultimately curtail our ability to provide fair and accurate decisions for disability applicants. The Michigan DDS's objective as a public agency is to carry out, as closely as possible, the mandates of Congress as expressed through the Social Security laws and regulations.

We wish to note by way of background that in the latter part of 1985, the Michigan DDS reached an on-duty staffing level of 605. This staffing level was reached at the Social Security Administration's (SSA) urging for the DDS to be ready to prepare for the implementation of the 1984 Social Security Amendments, an also indicating a need for additional DDS time-consuming responsibilities. However, as soon as the beginning of fiscal 1986, the direction had changed and the DDS was pushed toward downsizing. During fiscal 1986 and fiscal 1987, the Michigan DDS reduced staffing from the 605 level to approximately 480. In fiscal 1987 alone, the Michigan DDS will have reduced staffing by 103 employees. In fiscal 1988, it is again expected to downsize to 445. In fiscal 1989, it is anticipated that the DDS will be authorized 435 positions by SSA. At the same time, in October 1986, Michigan examiners had an average pending caseload of 85 claims, jumping in June 1987 to an average caseload of 115.4. This is an increase of 30.4.

RESPONSES TO COMMITTEE QUESTIONS

With this background, it is now our pleasure to respond to specific committee questions.

1. Have the severe restrictions placed by SSA on State Agency funding and staffing levels jeopardized the ability of the State Agency to properly implement the provisions of the Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460)?

   Although it has been very difficult, the Michigan DDS has been able to effectively manage the cutbacks in funding and staffing to date as previously indicated. However, continued SSA cutbacks will result in a significant deterioration of service to Social Security applicants.

The 1984 Act increased workloads by reinstating the periodic review and increased the amount of effort required to produce a decision on every case. The additional documentation requirements, specialized medical review criteria on mental claims, and the other initiatives have made the system more equitable. However, continued SSA budget cuts will negate the gains of the past three years in improving the adminstration of the program.

It is recommended that:

--The continuing SSA push for higher DDS productivity with less staff cease as soon as possible.

--The DDS must have a yearly SSA budget and this SSA budget authorization to the regions must be implemented in a more timely manner.

--The SSA must allow the DDS sufficient time to implement SSA program changes in an attempt to reduce potential for error.

--The DDS should be able to make hiring decisions after the SSA staffing authorization has been provided.

2. How has the State Agency responded to these budgetary constraints, and has this led to any deterioration in the quality and thoroughness of disability case development, documentation, and review?

The Michigan DDS has responded with an aggressive program in reaction to SSA budgetary constraints. This program includes:

--Downsizing DDS staff by 18 percent or 103 positions since 10/1/87.

--Reducing DDS medical expenditures by $2 million.

--Deploying 19 support staff (i.e., medical relations coordinators, trainers, etc.) into direct case processing assignments.

--Suspending temporarily the Quality Assurance Unit and reviewing and assigning 21 Quality Assurance personnel to casework processing activities.

While there has been little, if any, deterioration in the quality and thoroughness of DDS case development, documentation, and review, it is expected that continued SSA cuts will be devastating, impacting negatively on the quality of service and functions such as Quality Assurance, medical relations, and training.

The DDS has been able to sustain its high level of performance at a substantial expense; that is suspendsion of critical functions, such as medical relations activities, quality assurance reviews, staff training, etc. In time, the impact of the loss of these functions will result in:

--The deterioration of DDS documentation and accuracy of decisions from the 95% level due to a lack of internal quality control data used to identify problems and take corrective action.

--The loss of consultative examination vendors due to SSA's request that payments not be made for missed appointments. Missed appointments especially impact on psychiatric consultants. It is anticipated that as many as five percent of the psychiatric medical consultants may choose to terminate their relationship with the agency.

--Difficulty in responding to SSA program changes due to the loss of trainers.

It is our opinion that key DDS units, Quality Assurance and training, are being damaged to the point that it will take years to rebuild them. The bottom line is that the number of fair decisions resulting from the Disability Reform Act will decline due to inadequate funding.

It is recommended that SSA be encouraged to utilize appropriate strategies to ensure that DDS downsizing initiatives do not adversely affect DDS case quality, staff training and the accuracy of disability decisions.

3. Are SSA's productivity guidelines realistic, and is the method SSA utilizes to measure productivity accurate, consistent, or nationally uniform? If not, how could these productivity standards be improved?

During the months preceding 10/1/87, the Michigan DDS exceeded the SSA case production goal, referred to as PPWY (Production Per Work Year), of 205. However, DDS has paid a price by utilizing key support personnel to achieve production. The SSA productivity measure is not accurate, nationally uniform, nor realistic because inequities exist between DDS's in terms of how SSA workyears are calculated.

We feel that PPWY calculations by SSA are compounded by different variables from state to state and have no value for DDS evaluative nor comparative purposes.

It is recommended that SSA be directed to utilize the Cost Effectiveness Measurement System (CEMS) once it is perfected. This system adjusts for the differences in counting staff, translates and adjusts for state-by-state variables, and arrives at a common measurement for productivity.

4. Does a climate of crisis and disruption continue to plague the day-to-day administration of the disability program and, if so, how can order and stability--the key objectives of the 1984 legislation--be restored to the administrative process?

Throughout this year, a crisis climate has existed in the Michigan DDS. Staff have feared for their jobs through possible layoffs and have sought reassurance that DDS would not be required to close offices. This has resulted in a morale which is at an all time low. The real issue is the pendulum-like SSA program and budget messages which often change and leave the disability agency confused and unclear as to what the real SSA direction is.

It is recommended that SSA be encouraged to recognize that the primary methods for restoring stability to the DDS are to provide sufficient SSA funding for staffing, have reasonable performance standards, and have an implementation timetable that is based on DDS and SSA priorities. It is also recommended that SSA funding for DDS's be decentralized to emphasize greater use of its regional offices.

5. What is the condition of the Federal-State relations in administering the disability program, and what steps can be taken to improve the development and implementation of budgetary and adjudicative policy?

Relationships between DDS's and SSA have been strained, suspicious, and tense. Currently, SSA develops its preliminary budget and staffing figures for the DDS's based on artificially derived PPWY targets. Staffing targets should be based more upon the amount of work to be accomplished and the effort needed to produce a well-documented, fair decision. The SSA central office needs to be more responsive to DDS workpower feedback and to set DDS staffing levels and production standards.

The Michigan DDS has sought to work cooperatively with the Social Security Administration in a partnership agreement. This will require that both the SSA and the DDS listen to each other and accommodate state and SSA program needs. The SSA should uphold its side of the partnership by providing adequate staff and reasonable production standards.

Lastly, the recent experience of the Michigan DDS with the SSA Chicago Regional Commissioner's Office reflects a growing SSA sensitivity and recognition that the problems facing DDS's through SSA fiscal and program cutbacks can be managed on a regional level.

It is our belief that greater involvement of members of the Michigan Congressional Delegation has helped to facilitate this emerging and responsive development.

It is recommended that SSA budget and planning priorities be decentralized to emphasize the role of the Regional Office in assisting the DDS's on the local level.

In summary, we wish to thank you for this opportunity to present our views on the impact of SSA cutbacks on Michigan disability claimants, Social Security beneficiaries, and the DDS staff who make the disability decision.

Chairman Jacobs. Thank you, sir. Mr. Johnston.

STATEMENT OF PHILIP W. JOHNSTON, SECRETARY, MASSACHUSETTS EXECUTIVE OFFICE OF HUMAN SERVICES, ACCOMPANIED BY KASPER M. GOSHGARIAN, DEPUTY COMMISSIONER, MASSACHUSETTS REHABILITATION COMMISSION

Mr. Johnston. Thank you, Mr. Chairman. And I join Mr. Cotman in thanking you and the members of the subcommittee for allowing us to bring our views from the Commonwealth of Massachusetts on this very, very important issue. I am accompanied by Kasper Goshgarian, who is the deputy commissioner of the Massachusetts Rehabilitation Commission, which has the responsibility for the administration of the program in Massachusetts.

I have submitted a written statement which I would like to take certain portions from in order to stay within the 5-minute limitation.

We are very appreciative of the role that this subcommittee played and the entire Congress played in bringing out the Reform Act of 1984. Several members of our Massachusetts congressional delegation played key roles, Congressman Donnelly, who had been a member of this subcommittee in the past, Congressman Frank, Congressman Markey, Congressman Studds and a number of others.

And we thought that we were on the road to terrific things happening for disabled in this country as the result of the enactment of that legislation. Policy issues certainly were corrected by the legislation in 1984, but because of the fiscal practices and policies of the Social Security Administration, disabled persons in Massachusetts and throughout the country are continuing to suffer, Mr. Chairman.

I would like to go through what our reductions in Massachusetts have really looked like during the past couple of years. In fiscal 1986, we had 42,237 cases. Fiscal 1988, we are looking at 46,528. So that the caseload has increased rather substantially. The staffing level, however, has decreased from 354 in fiscal 1986 to 261 in fiscal 1988. Funding has dropped from $20.6 million in 1986 to $18.3 million in 1988. Just this year alone we will be experiencing a decrease in the budget of about $1 million. There has been an 11 percent cut in this budget, an overall staff reduction of 26 percent.

In fiscal 1987, the Massachusetts DDS experienced significant difficulties in implementing the intent of Congress. We informed SSA that mental impairment cases took twice as long as before due to the documentation requirements. We requested additional staffing and funding resources to properly implement your intent regarding mental impairment claims.

Instead of providing these resources, SSA decreased the documentation requirements, thereby creating a process which was not significantly different than that utilized prior to the implementation of the reform act. We were forced to periodically furlough in-house physicians, to reduce their hours, to delay the ordering of necessary examinations and increase case processing time.

When our congressional delegation from Massachusetts made our concerns known to SSA, the solution of SSA was to immediately order an audit of our agency. SSA mandated the DDS in Massachusetts to be "more productive." This was to be accomplished by reduced physician review, reduced medical documentation, and the elimination or reduction of necessary support services like community relations, medical relations, quality assurance training and so on.

When you combine those actions with significant staff reductions, it was pretty clear to us, and it remains pretty clear that this is clearly their intent to counter Congress' action to implement a more comprehensive program to provide accurate quality decisions.

In fiscal 1988, the situation is even worse for us in Massachusetts. SSA has essentially directed the further reduction of over 30 staff by October 1 of this year. Such layoffs have already occurred in several other States within Region I and nationally. These are the very same individuals that SSA directed us to hire in fiscal 1986.

The net effect of these additional staff reductions should be evident to all of us, and they include, increased caseload size leading to poor case management, inadequate medical documentation, decreased accuracy of decisions, decreased overall allowance rate, decreased physician input in decisionmaking, poor staff morale, increased consumer complaints, and increased administrative law judges and court appeals.

This does not sound, Mr. Chairman, like the new era we promised ourselves and the disable in Massachusetts and throughout the country. In fact, the net effect will be quite the opposite. Again, we will hear of the horror stories of suicides, depression and helplessness. Again, we will lose public confidence. Again, we will see labor-management disputes over unmanageable caseloads and working conditions.

On behalf of Governor Dukakis and the Commonwealth of Massachusetts, I wish to again thank Congress and this subcommittee for your wisdom in the enactment of the 1984 Reform Act. We need additional help, unfortunately, in 1987 to help the disabled.

[The statement of Mr. Johnston follows:]

TESTIMONY OF PHILIP W. JOHNSTON, SECRETARY OF HUMAN SERVICES
TO
THE SUBCOMMITTEE ON SOCIAL SECURITY
ON TUESDAY, OCTOBER 6, 1987
IN WASHINGTON, DC

I would like to take this opportunity to thank Chairman Andy Jacobs and the members of the Social Security Subcommittee for this opportunity to provide testimony regarding the understaffing and underfunding issues that confront the integrity of the national Disability Program. The Commonwealth has a long history of concern for the health and welfare of disabled individuals. As compassionate government leaders, it is our obligation to assure fair and equitable services to all persons in need and eligible for services. This is not a choice but rather a mandate for any civilized society.

The Social Security Disability Program is clearly the major national program that provides necessary financial benefits to those individuals unable to work due to disability. In the past, it has been a model government program providing consistent national services. However, this era came to a sudden halt beginning in 1981 with the accelerated CDR program. Governor Dukakis and I, upon assuming office in 1983, were inundated with complaints from a large and varied constituency. We personally witnessed horror stories where truly disabled individuals were ceased from the disability rolls without any improvement in their medical condition. It became evident that these individuals were the innocent victims of a system that changed the ground rules in midstream.

We brought our concerns to this administration in an attempt to bring saneness to an out-of-control system. Unfortunately, our concerns were unheeded. Therefore, Governor Dukakis directed the Massachusetts Disability Determination Services to devise and implement a medical improvement standard effective April, 1983. This standard was based on First Circuit Court of Appeals case law. Upon its implementation, the untold suffering ceased.

I am proud to say that the members of the Massachusetts Congressional Delegation, as well as other key Congressional leaders, provided outstanding support and national direction. Their efforts, combined with the activities of our constituents as well as those throughout the nation, resulted in the enactment of the Disability Benefits Reform Act of 1984. The Reform Act ensured that the Disability Program would operate under sound national policy and guidelines.

Unfortunately, what we had anticipated did not become reality. Although Congress enacted comprehensive legislation, and regulations were developed, this administration has chosen to underfund and understaff the operations of this program. Inadequate resources are just as harmful to disabled individuals as inadequate policies. The net effect is incorrect decisions based on an inadequate data base.

Equally important is the fact that we have communicated false information to our constituents. With the passage of the Reform Act, we told them that we were entering a new era of compassionate services where the truly disabled would be provided the benefits to which they were entitled. We said that the horror stories were over and they could once again trust the government which they once supported with their tax dollars and Social Security Disabilty contributions. Unfortunately, we were not communicating correct information. In reality, although Congress corrected the policy issues, disabled individuals would continue to suffer as a result of Social Security's funding practices.

The true effect of these funding practices first appears in federal FY'86. Prior to that time, it appeared that Social Security was making an honest attempt to correct its systemic problems. By example, in FY'85, all DDS's were directed by SSA to increase their staffing to meet the more comprehensive documentation requirements of the Reform Act. Also, new mental impairment policies and procedures were developed. The medical improvement standard appeared to be both fair and compassionate. This was the new era for which we had hoped. Finally, we thought stability was restored.

Unfortunately, our hopes were short lived. In FY'87, SSA's emphasis changed from compassionate services to productivity at all costs. In federal FY'86, we were instructed to hire additional staff to implement the provisions of the Reform Act. In FY'87, we were ordered to dramatically reduce staff and our purchase of necessary medical services. In FY'88, further reductions were mandated. The following data demonstrates this point for Massachusetts:

	FY'86	FY'87	FY'88
Cases:	42,237	47,430	46,328
Staffing:	354	296	261
Funding:	$20,648,836	$19,167,000	$18,370,431

The Disability Reform Act of 1984 called for more comprehensive procedures for documentation and review. Yet, it should be obvious that such policies cannot be implemented with an increased workload combined with an overall staff reduction of 26% and budget reduction of 11% (unadjusted for inflation).

In FY'87, the Massachusetts DDS experienced significant difficulties in implementing the intent of Congress. We informed SSA that mental impairment cases took twice as long as before due to the documentation requirements. We requested additional staffing and funding resources to properly implement Congress' intent regarding mental impairment claims. Instead of providing these resources, SSA decreased the documentation requirements, thus creating a process which was not significantly different than that utilized prior to the implementation of the Reform Act. We were forced to periodically furlough in-house physicians, reduce their hours, delay the ordering of necessary examinations and increase case processing time. When our Congressional Delegation made our concerns known to SSA, its solution was to order an audit of our agency. SSA mandated the DDS to be more productive. This was to be accomplished by reduced physician review, reduced medical documentation, and the elimination or reduction of necessary support services (i.e. Community Relations, Medical Relations, Quality Assurance, Training, etc.). Combined with significant staff reductions, this clearly was counter to Congress' intent to implement a more comprehensive program that provides accurate, quality decisions.

In FY'88, the situation is even worse. SSA has essentially directed the further reduction of over 30 staff by October 1, 1987. Such layoffs have already occurred in several other states within Region I, and nationally. These are the very same individuals that SSA directed us to hire in FY'86. The net effect of these additional staff reductions should be evident and are as follows:

1. Increased caseload size leading to poor case management.
2. Inadequate medical documentation.
3. Decreased accuracy of decisions.
4. Decreased overall allowance rate.
5. Decreased physician input in decision making.
6. Poor staff morale.
7. Increased consumer complaints.
8. Increased Administrative Law Judges and Court Appeals.

This does not sound like the new era we promised ourselves and our constituencies. In fact, the net effect will be quite the opposite. Again, we will hear of the horror stories of suicide, depression and helplessness. Again, we will lose public confidence. Again, we will see labor management disputes over unmanageable caseloads and working conditions.

In 1982, we were given an opportunity to correct the inequities in this program. On behalf of Governor Dukakis and the Commonwealth, I wish to thank Congress for its wisdom in the enactment of the 1984 Reform Act. I wish I could come before you and tell you that your intent has been met and will continue to be met in Massachusetts.

Unfortunately, this is not my mission. Rather, I must inform you that the intent of this important legislation is in jeopardy. We are administering a program that is today tenuous at best. We made our promises to our constituents but may be unable to deliver due to SSA's budget policies. I certainly am not opposed to productivity. However, productivity at the expense of disabled individuals is not and will not be the operational principles of this Commonwealth. For this reason, I respectfully request that the necessary funds be made available to administer this program in accordance with Congressional intent. We may not have a second chance.

Thank you.

Chairman **JACOBS**. Mr. Levin will inquire.

Mr. **LEVIN**. Welcome to both Dr. Cotman from Michigan and to Mr. Johnston—and you are accompanied by Mr. Goshgarian?

Mr. **JOHNSTON**. Yes.

Mr. **LEVIN**. It is difficult to react to your testimony because one wonders just what in the world is going on and why. You come from two States, I think, appropriately well known for good government at the State level. I mean that seriously.

What is going on? I mean, what is motivating this conflict? Maybe you do not want to answer that. But what is the dynamic of all this? Do you have any idea?

Mr. **JOHNSTON**. My own feeling, Congressman, is that this is really based, grounded in a philosophy, a political philosophy which emanates from the highest levels of the Federal administration, which is that they do not believe that it is a valid role for government to—Federal Government at least, to be reaching out and helping disabled persons.

We have seen that over the last 7 years. It is a scandal. It is a disgrace. It is a tragedy. I could document, and we have documented to the subcommittee in the past, tragedy after tragedy after tragedy in our own State, where cases that were very avoidable had the Federal Government, had the national administration taken a more appropriate view of this issue.

Mr. **COTMAN**. Congressman, I concur. I have been in this program since 1973 and an associate superintendent since 1979, and I have become critically aware of the fact that this program being 100 percent federally funded expresses clearly, almost dramatically in the lives of thousands of people in Michigan and millions of people across the country, the philosophy of the Executive Office, with respect to reduction in service, with respect to reduction in cost, with respect to the allegations of increased efficiency, and with respect to shifting to the States the responsibility for programs which have in the past provided excellent service and adequate services through—under the auspices of Federal funding.

Mr. **LEVIN**. Your testimony highlights personnel reductions, and I am not sure how that cuts. I think it is important to continue to illustrate for us the impact in human terms. Because if you just—if one highlights, and you do not really highlight; I mean, that is not where you are coming from—but when testimony focuses on staff reductions, I think most people kind of cheer. It is the impact, when they see the impact on people, then most Americans no longer cheer.

If the issue is, is there a bloated bureaucracy or not, it is pretty clear what most people feel. I think that there is inefficiency. But I think we have learned that the Reagan administration has misshaped the facts about the bureaucracy.

But anyway, it is really what it all means in human terms. And I think the more you can illustrate that, give us the facts on that, the better.

Thank you very much. And again, Mr. Chairman, though this may not catch the headlines very readily, it seems to me vitally important that the subcommittee under your leadership continue this effort.

Mr. **Goshgarian**. Mr. Chairman, if I could make a quick comment about the human terms as an administrator of the program. I came into the DDS program in the midst of the CDR crisis in 1982. And essentially, in Massachusetts we had a program that was not very responsive, all the time at least, to exactly those needs you speak to, the human needs.

We worked hard with the staff within the agency to assure that in human terms the decisions we made were based on an adequate medical and other data base. In that period, we increased the allowance rate in this program from about 28 percent in 1983 to currently in Massachusetts about 47 percent, with high accuracy. So we are not only allowing more people, we are doing it in an accurate way.

One of the problems with staffing cuts is, as you reduce staff you also reduce the comprehensive medical documentation requirements of this program. And with that, we predict that in fact our allowance rate may well go down. And once that happens and we start approaching allowance rates that we were experiencing in 1982 and before, we are again letting down the disabled people in this program.

And I think that is a factor in this program anyway, because we talk about a national program. But really how national is it when the allowance rate in this program varies from 18 percent in one State to 47 or 48 percent in another? Where medical time per case varies from 4 minutes per case in one State to an hour or more in another?

So I think really the national—SSA calls for increased productivity and national consistency, and we agree with that. But national consistency has to include more than just PPWY. It has to include the issues of allowance rate, how staff are employed, how we document cases, and really our compliance with the intent of Congress on the 1984 Disability Reform Act.

Chairman **Jacobs**. In the case of old age and survivors, it is well known that the computer hardware has been varied over a period of time. And there is some confusion in relating the software to the hardware. I assume that has some impact on the disability system as well, does it not? And if so, would you care to comment on the administration's assertion that the reduction in personnel goes hand in hand with the improvement of the technology with which data is retrieved, and therefore, applied?

Mr. **Cotman**. Let me just say that, and this is with respect to Congressman Levin's point as well, the 95,000 people who will be served in Michigan will be adversely affected by the reduction in staff in the following ways. There will be about $2 million in medical expenditures they will not have available to them. Therefore, increasing the likelihood that the decision will be made to not provide them with the Social Security disability benefits they need.

Second, because of the cutbacks, we have been forced to place some of our staff who were in quality control positions into case processing positions. That forces us to run the risk of increasing errors again while making disability decisions, thereby not giving persons a fair decision based on the experience of staff who would have been in those positions.

I am unaware of the status of our computers, but with respect to the human aspect of it, these have some direct corollaries to the amount of time it takes to process a claim, the amount a person will be allowed which we expect will decline, the number of days it takes, the amount of medical evidence that will be required, and ultimately the number of people who will be stricken from the rolls as a result of the speed-up by SSA for greater productivity.

Chairman JACOBS. Mr. Johnston?

Mr. JOHNSTON. Mr. Goshgarian really has the technical knowledge in software and hardware, if he would like to comment.

Mr. GOSHGARIAN. I am not sure I have that knowledge, but my comment on the issue is, the issues of software-hardware have not been a major one for the DDSs in terms of productivity or one of freeing up staff. The one thing I can say is, the reporting requirements for this program have become more comprehensive rather than less comprehensive. So actually, the interface and all has cost us more staff hours rather than less.

Chairman JACOBS. Progress of this kind does not necessarily mean improvement.

Mr. GOSHGARIAN. I think in the long run it will certainly give a better data base to both the state agency and Social Security Administration, and that may indeed translate to improvement. But in terms of saving manyears or work years, it really has not been an improvement in our judgment, and I would guess the judgment of most States.

Chairman JACOBS. That is what I wondered about. It logically would mean improvement in the case of old age and survivors where most transactions are just retrieval of data and treatment of it in a fairly administerial fashion.

You have enriched the record. Thank you very much for your contribution.

The final panel consists of the Massachusetts Determination Service Advisory Committee, Alan Root; and the National Committee to Preserve Social Security and Medicare, Martha McSteen, an old friend of the subcommittee. You are most welcome, Ms. McSteen. I am sorry your fellow Texan is not here to conduct the matter, but I am sure he is here in spirit. He is almost everywhere that way.

STATEMENT OF ALAN ROOT, MEMBER, MASSACHUSETTS DISABILITY DETERMINATION SERVICE ADVISORY COMMITTEE

Mr. ROOT. Mr. Chairman, if you are an American worker, up to $3,000—more than that, $3,131.70, to be precise, will be deducted from your 1987 wages to protect you and your family when you are too old to work, or if you become too disabled to work.

Tens of millions of American wage-earners work under the cruel delusion that the Social Security disability program will be there if they should ever need it. What the average American worker does not know is—that if you become too ill to work—the Social Security Administration will confront you with a monumental and far-reaching obstacle course—designed to humiliate you, break your spirit, and deny you benefits.

The 1984 Disability Reform Act was supposed to change all that. It used to be said around here that "the President proposes and the Congress disposes." The new game plan in town seems to be "what the Congress enacts, the bureaucracy subtracts."

As a Social Security disability recipient, I would like to say that we are very distressed as a group by many of the actions of Social Security, particularly since the arrival of the new commissioner. We feel that there is an agencywide attempt to turn back the clock by undermining the 1984 reform measures. To reverse this alarming trend, we are offering the following recommendations.

One, that Congress direct the Social Security Administration to conduct an independent and scientifically based study on caseloads for State disability determination services. Such a study should take into consideration regional and State differences so as to arrive at a nationwide standard which reflects quality decisionmaking.

Two, that Congress direct the Social Security Administration to implement regulations which require that decisions on disability claims be based primarily on the medical evidence of record and that consultative examinations should be the exception rather than the rule.

Three, that Congress direct the Social Security Administration to ensure that the State disability determination services have adequate time for their examiners and doctors to review files. Investment of resources at this level will result in fewer resources needed at the appellate levels.

Four, that Congress direct the Social Security Administration to ensure that Social Security's Federal quality assurance units are not used to effectuate substantive changes in the law and regulations without having such changes published pursuant to the requirements of the Administrative Procedure Act.

And five, that Congress enact legislation which would award interest on any retroactive award received by an SSDI or SSI beneficiary. There is a precedent for that with the IRS, which after the enactment of such legislation now processes claims more expeditiously.

Mr. Chairman, the Social Security Disability Program is once again at a crisis point. This Congress must decide what legacy it will leave to people with disabilities and to people who will become disabled. Is there anyone here or across this Nation who does not feel they have an obligation to the disabled person or to that disabled person that she or he or you might someday be?

Congressional inaction at this time will leave in place a program which will continue to be plagued by conflict from within and without. Congressional inaction will leave tens of millions of American workers wondering about why they pay Social Security taxes. Congressional inaction will leave our people wondering whether their Government really intends to protect them and their families when threatened by disabling conditions.

Congressional action which mandates fair and equitable procedures and standards on a nationwide basis is the only alternative if Congress really wants to assure disabled people that their legal rights will be really protected. Social Security must not be allowed to hold disabled people hostage by a system which is arbitrary and which causes immeasurable hardship to people who have a reduced capacity to fight an irrational, insensitive, heartless, cruel, abusive and callous bureaucracy.

[The statement of Mr. Root follows:]

House Subcommittee on Ways and Means
Room B316
Rayburn House Office Building
Washington, D.C. 20515

PREPARED STATEMENT OF ALAN ROOT

Mr. Root is a member of the Massachusetts DDS Advisory Committee and plans to deliver this testimony personally at the July 1, 1987 hearings on the Social Security Disability Amendments of 1984.

If you are an American worker, up to $3131.70 will be deducted from your 1987 wages to protect you and your family when you are too old to work...or if you become too disabled to work. Tens of millions of American wage-earners work under the cruel delusion that the Social Security Disability Program will be there if they should ever need it. What the average American worker does not know is -- that if you become too ill to work -- the Social Security Administration will confront you with a monumental and far-reaching obstacle course -- designed to humiliate you...break your spirit...and deny you benefits.

The 1984 Disability Reform Act was supposed to change all that. It used to be said around here that "the president proposes and the congress disposes." The new game plan in town is that "what the congress enacts, the bureaucracy subtracts." Let me be specific.

National statistics show that the use of Social Security's medical consultants varies from state to state. One state reports that its medical consultants spend only 4 minutes per case! That's right -- just 4 minutes per case! Other states, such as Massachusetts' medical consultants spend an average of 57 minutes per case. Despite the common-sense fact that it is literally impossible to read a case file in 4 minutes, much less thoroughly review the file in such a short period of time -- Social Security points to those states using the least amount of time as the model which other states are to follow. They do this by cutting funds for medical consultants in those states where medical consultants spend more time in reviewing cases. And any objections from these states are met with Social Security's suggestion that medical consultants do not actually have to write an RFC -- they only have to sign one -- one that is actually prepared by a non-medically trained examiner.

In similar fashion, Social Security has set up what it calls "production standards" for the state-operated Disability Determination Services. These so-called "production standards" are not real standards arrived at through any scientific study. Actually, these so-called "standards" are the production levels of those states which process large numbers of cases in short periods of time. And other states, such as Massachusetts, which do not produce such exaggerated numbers of cases per year, but which maintain consistently high accuracy rates -- are told by Social Security that they must increase their total number of cases with less funds and fewer staff. Again, Social Security's message is clear...develop more cases faster but don't worry about whether they are developed thoroughly or fairly.

This emphasis on high case production without an equal commitment to quality was one of the most glaring injustices that led to the 1984 Reform Amendments. If Social Security continues its actions along these lines, how long will it be until we return to the pre-1984 Neanderthal scenario of non-stop Administrative Law Judge hearings...judicial log jams...regional inequities...and even louder demands for real reforms.

Social Security's attempts to undermine the quality of decision-making is one thing. But they are also undermining other provisions of the 1984 Reform Act. Again, being specific.

The 1984 Reform Act mandated that people who lost their benefits without an evaluation under a medical improvement standard were supposed to have their cases reviewed under that new standard. Yet in 1987, there are still thousands of people who have not had their cases reviewed under the new standard...or having been found eligible under a medical improvement standard -- have yet to receive the retroactive benefits to which they are entitled. The hardship to these disabled people continues -- despite Congress' intent to alleviate such hardship.

The 1984 Reform Act also directed Social Security to implement a new and realistic standard for evaluating persons with mental impairments. Once this new standard was finally implemented, statistics showed that more mentally-impaired people were being found eligible for benefits. This increased number of allowances was attributed to the new and more realistic assessment of mental impairments. However, the new Social Security Commissioner is now trying to change these mental impairment standards by introducing what she calls "work short cuts". If a mentally-impaired gentleman reports that he does his grocery shopping, Social Security's work short cut says that is enough documentation. The examiner will not inquire as to whether or not the mentally-impaired gentleman shops by himself, requires assistance or even purchases the appropriate items.

These Social Security initiatives are clearly directed at reducing the number of allowances for mental impairment claims. Further evidence of this can be concluded from the fact that Social Security makes special visits to regional offices which have high allowances for mental impairments.

Since the enactment of the 1984 Disability Reform Act, the Massachusetts Disability Determination Services Advisory Committee has worked diligently with the Massachusetts DDS to ensure that disabled persons are treated fairly and that their cases are thoroughly developed and documented. The decisions from the Massachusetts DDS have shown increased quality as evidenced by the fact that the number of appeals for Administrative Law Judge hearings has decreased significantly. Our Advisory Committee maintains a close watch on what is happening on disability reform not only within our state but across the nation.

We are distressed by many of the actions of Social Security, particularly since the arrival of the new Commissioner. We feel that there is an agency-wide attempt to turn back the clock by undermining the 1984 reform measures. To reverse this alarming trend, we are offering the following recommendations:

1. That Congress direct the Social Security Administration to conduct an independent and scientifically based study on caseloads for state Disability Determination Services. Such a study should take into consideration regional and state differences so as to arrive at a nationwide standard which reflects quality decision-making.
2. That Congress direct the Social Security Administration to implement regulations which require that decisions on disability claims be based primarily on the medical evidence of record and that consultative examinations should be the exception rather than the rule.
3. That Congress direct the Social Security Administration to ensure that the state Disability Determination Services have adequate time for their examiners and doctors to review files. Investment of resources at this level will result in fewer resources needed at the appellate levels.
4. That Congress direct the Social Security Administration to ensure that Social Security's Federal Quality Assurance units are not used to effectuate substantive changes in the law and regulations without having such changes published pursuant to the requirements of the Administrative Procedure Act.
5. That Congress enact legislation which would award interest on any retroactive award received by a SSDI or SSI beneficiary. There is a precedent for that with the IRS, which after the enactment of such legislation, now processes claims more expeditiously.

The Social Security Disability program is once again at a crisis-point. This Congress must decide what legacy it will leave to people with disabilities and to people who will become disabled. Is there anyone here or across this nation who does not feel they have an obligation to the disabled person that he or she might someday be?

Congressional inaction at this time will leave in place a program which will continue to be plagued by conflict from within and without. Congressional inaction will leave tens of millions of American workers wondering about why they pay Social Security taxes. Congressional inaction will leave our people wondering whether their government really intends to protect them and their families when threatened by disabling conditions.

Congressional action which mandates fair and equitable procedures and standards on a nationwide basis is the only alternative if Congress really wants to assure disabled people that their legal rights will be really protected. Social Security must not be allowed to hold disabled people hostage by a system which is arbitrary and which causes immeasurable hardship to people who have a reduced capacity to fight an irrational, insensitive, heartless, cruel, abusive and callous bureaucracy.

Alan Root
33 Kellogg Avenue
Amherst, MA 01002

Chairman JACOBS. Thank you for your statement. Ms. McSteen?

STATEMENT OF MARTHA McSTEEN, MANAGEMENT CONSULTANT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Ms. McSTEEN. Mr. Chairman, I would like to make a few comments and submit the full testimony for the record. I am Martha McSteen of the National Committee to Preserve Social Security and Medicare. I am here representing approximately 4.5 million members of our organization, many of whom have written us concerning problems they have with disability claims.

As both the Regional Commissioner of Social Security in Dallas regional office, and as the Acting Commissioner of the Social Security Administration for nearly 3 years, I have faced many of the same questions that you are facing and addressing today.

Mr. Chairman, I appreciate the fact that you have scheduled this hearing to solicit facts and ideas and comments regarding the administration of the disability program in the DDS's. Any disruption in the administration of the program adversely affects beneficiaries, whether it is through delayed processing or inaccurate decisions.

The national committee staff members have personally talked to State program managers throughout the country. From all accounts, a climate of crisis does exist in many DDS's; a climate which many believe can be changed with more open communications between the DDSs and the SSA.

Unfortunately, a sense of shared responsibility between state agencies and SSA has been replaced by dogmatic and autocratic SSA directives, which are themselves an impediment to restoring stability to the program. Mandates given without consideration of mitigating or varying circumstances have only been disruptive.

SSA sets goals and the level of productivity and the DDSs are expected to meet those goals without necessarily being given the budget needed to employ and maintain adequate staff. The name of the game, according to one DDS, is productivity per work year.

We have been told that some DDSs have said to SSA, just tell us what you want and we will produce it. Although many managers are uncomfortable with shortcuts, DDS's are generally producing the results that SSA has demanded.

A foreboding development, as it relates to quality, is SSA's insistence on taking claims by telephone or having claimants fill out their own claims forms. When claims are not properly developed and documented before they reach the DDS, a disability examiner has only two options. The claim can be decided on the basis of the information available or the DDS can send it back to the claimant or to the Social Security office and request additional documentation.

Each DDS is a unique operation with specific needs. Differences between State operations have developed for a variety of reasons, perhaps self-imposed, or directed processing freezes, state hiring freezes, and insufficient number of qualified medical personnel.

The goal must be prompt, accurate, nationally consistent disability decisions. Variations from 75 to 44 percent in the rate of denial of initial claims raises serious questions as to the accuracy and the consistency of disability decisions around the country. Neither regional nor State efforts can achieve consistent, accurate decisions when productivity and budget cutbacks are the priority.

We believe that SSA must: First, set specific, clear and current guidelines and directives, and ensure that decisions are prompt, accurate and nationally consistent. Second, grant State and regional management flexibility at the local level in budgeting, staffing and training, and at the same time demand accountability for meeting performance standards.

My full written statement also refers to the need to remove inequities and inconsistencies and arbitrary restrictions on benefits to disabled individuals.

Again, Mr. Chairman, thank you for this opportunity to appear before you with our concern about the disabled claimant.

[The statement of Ms. McSteen follows:]

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

1300 19th Street, N.W., Suite 501, Washington, D.C. 20036 (202) 822-9459

STATEMENT OF MARTHA MC STEEN

FOR THE

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

PRESENTED TO

THE HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON SOCIAL SECURITY

HEARING ON

ADMINISTRATION OF THE

DISABILITY INSURANCE PROGRAM

OCTOBER 6, 1987

I am Martha McSteen of the National Committee to Preserve Social Security and Medicare. I am here representing the four and a half million members of our organization, many of whom have written us about difficulties with disability claims. As both Regional Commissioner in the Dallas, Texas, Regional Office of Social Security and as Acting Commissioner of Social Security for nearly three years, I have faced many of the same questions you are addressing today.

Mr. Chairman, we appreciate the fact that you have scheduled this hearing to solicit facts and comments regarding administration of the Disability Insurance program in the state Disability Determination Services (DDSs). Any disruption in the administration of the program adversely affects beneficiaries whether it be through delayed or inaccurate decisions

National Committee staff members have personally talked to state program managers throughout the country. From all accounts a climate of crisis does exist in many DDSs -- a climate which many believe can be changed with more open communication between DDSs and the Social Security Administration (SSA). Unfortunately, a sense of shared responsibility between state agencies and SSA has been replaced by dogmatic and autocratic SSA directives which are themselves an impediment to restoring stability to the program and its operations. Mandates given without consideration of mitigating or varying circumstances have only been disruptive.

SSA sets goals and the level of productivity and the DDSs are expected to meet those goals without being given the budget needed to employ or maintain adequate staff. The "name of the game," according to one DDS, is Productivity Per Work Year. The day-to-day mode is one of "cutting corners," looking for ways to get around requirements outlined in the 1984 Disability Amendments.

We have been told that some DDSs have said to SSA "Just tell us what you want and we will produce it." Although many managers are uncomfortable, DDSs are producing the results that SSA has demanded. In order to meet productivity standards, in the words of one manager, "We are not developing cases to the degree necessary. We are not obtaining consultative examinations or writing rationales." For example, consultative examinations have been reduced dramatically to about 38 percent of the cases. Consultative examinations, complete documentation and written rationales all contribute to better decisions.

In states faced with excessive backlogs, managers of course, were critical of budget and staffing cuts. Here is what some have said:

> "Continuing disability reviews are delayed; we've put them on the back burner."
>
> "Hearing officers trained for face-to-face reconsiderations are working on initial claims."
>
> "People who know their claims were diaried for review are worried because they haven't heard from us. I don't know when we will get to them."

The most disturbing comments, however, came from those states which are currently meeting productivity goals, but only at a severe price in job related stress with consequences for the quality of disability decisions.

> "Individual pending caseload is well over a hundred. There is no question there has been terrible strain."

> "I don't know what a good productivity standard is. We scrambled, pushed harder and our PPWY (Productivity Per Work Year) has been increased for next year. How hard do you push before you start getting sloppy, before you reach the breaking point?"

> "We will finish the fiscal year with a productivity of about 190. The reason is that we started the year with 16 percent more people than we have today. Beginning October 1, we will drop another six percent. More claims are being filed. The workload is continuing to rise. We have been out of compliance for two consecutive quarters. Now we are scheduled for mandatory technical assistance!"

Equally as disturbing, as it relates to quality is SSA's insistence on taking claims by telephone or having claimants fill out their own claim forms. Numerous complaints and concerns surround these practices, particularly with disability claims. When a trained claims representative completes the form, he or she has an opportunity to observe the applicant, to ask the probing questions necessary to bring out all relevant facts about the claimant's disabilities as well as his or her prior work experience and to thoroughly develop issues that arise as the applicant responds to questions. When claims are not properly developed and documented before they reach the DDS, a disability examiner has only two options. The claim can be decided on the basis of incomplete information or the DDS can go back to the claimant or the local Social Security office and request additional documentation. Given the constraints now imposed on DDSs, I am fearful that the first option will most often be taken.

In the view of DDS personnel, lines of communication must be reopened to improve this crisis situation. Only then can SSA restore confidence and stability. Federal and state agencies must meet on a state-by-state basis, in an atmosphere of mutual respect and cooperation, if they are to set reasonable and attainable productivity and budgetary goals.

Each DDS is a unique operation with specific needs. Differences between state operations have developed for a variety of reasons. They include a history of self-imposed or SSA-imposed processing freezes, state hiring freezes, inadequate state salary structures which have rendered the agencies unable to compete with private sector salaries, weak management teams, an insufficient number of qualified medical personnel and, in some instances, a prior history of poor communication and relationship with the Regional SSA office.

The goal should be prompt, accurate, nationally-consistent disability decisions. Variation from 75 percent to 44 percent in the rate of denial of initial claims raises serious questions as to the accuracy and consistency of disability decisions around the country. Neither regional nor state efforts can achieve consistent, accurate decisions when productivity and budget cutbacks are the priority. The application of national standards simultaneous with the imposition of across-the-board budget constraints has resulted in frustration, increased job stress, shortcuts to meet quotas and inaccurate decisions.

Centralization of the budget has severely restricted the regions and states in their ability to be responsive to individual DDS needs. DDSs and the regions must be allowed flexibility, accompanied by accountability, for improvement of the process. Productivity and performance standards must emphasize quality decisions. Strengthening state agencies will require intensive team effort, joint goal setting, adequate staff, and appropriate training.

This will be most easily accomplished in regions and states with strong, cooperative relationships, but where such relationships do not exist, they must be built or rebuilt.

To summarize our recommendations, SSA must:

- Set specific, clear and current guidelines and directives and ensure that decisions are prompt, accurate, and nationally-consistent, and
- Grant state and regional management flexibility at the local level in budgeting, staffing, and training and demand accountability for meeting performance standards.

New and improved tools also are essential to increase productivity and still achieve accurate decisions. If the tools are imperfect or too difficult to use, disability examiners will either waste time trying to do the job right or simply throw up their hands in frustration and make plausible, but imperfect, decisions.

One of the most important tools used by disability examiners is the Dictionary of Occupational Titles, the national encyclopedia of the more than 12,000 jobs in our economy. It is essential that the Dictionary, which has not been fully updated in ten years, be brought up-to-date and kept up-to-date. Its purpose is to provide accurate information about the existence, skill requirements, and physical demands of jobs in our economy. Disability examiners use the Dictionary to match the abilities of the disabled individual with jobs in the economy and are required to render decisions consistent with the Dictionary. When the Dictionary is wrong, disability decisions can be wrong.

Disability examiners must now manually search through what one examiner described as "a very large library." In the words of a branch manager, "Shortcuts are taken by necessity of time. It is not realistic to do the kind of job necessary to review manually, to give the kind of vocational assessment that an automated piece of equipment can do." This is a task that can and should be handled by an automated system.

Testing of a Computer Assisted Vocational Evaluation System (CAVES) was completed a year ago by DDSs in Kansas, Texas and Washington. Examiners who used the program on a test basis report that CAVES led to better decisions because the program demanded more thorough documentation and because the program had the ability to research the entire job base. Agencies which tested CAVES submitted their reports to the Social Security Administration a year ago, but have heard nothing since. Refinement and installation of CAVES in all DDSs will improve productivity as well as increase the likelihood that disability decisions will be both accurate and consistent throughout the nation.

Finally, a "climate of crisis" in the administration of the program is not the only problem affecting disabled individuals. In our legislative plan for the 100th Congress, the National Committee advocated removing inequities, inconsistencies, and arbitrary restrictions on benefits to disabled individuals.

The National Committee spelled out its recommendations in testimony before the Disability Advisory Council. As an appendix to this statement, we have attached excerpts from our testimony to the Advisory Council. We urge the Subcommittee to review our recommendations.

We thank you, Mr. Chairman, for this opportunity to express our concern for the need of disabled individuals to be able to rely on the equity, accuracy and timeliness of disability decisions.

APPENDIX

Excerpts from Testimony of The National Committee to Preserve Social Security and Medicare before the Disability Advisory Council, June 2, 1987

DEFINITION OF DISABILITY

Congress severely narrowed the definition of disability for widows and dependent widowers when benefits were awarded to disabled survivors -- but with the understanding that limitations could be lifted in subsequent legislation. Barred from consideration were limitations on workforce participation imposed by vocational factors such as advanced age, inadequate education or lack of labor market experience. Only severe physical or mental impairments could be evaluated.

Two additional restrictions were added. First, the disability had to occur within seven years of the death of the spouse or seven years from the time the youngest child reached age 16 (age 18 prior to 1981 Budget Act). Second, the widow(er) had to be unable to engage in any gainful activity (note the absence of the word "substantial" as compared to gainful activity criteria for disabled workers).

The belief that severe disability entitles a worker to unreduced benefits regardless of actual age was not carried over to disabled surviving spouses. Initially benefits were reduced for each month the widow(er) was less than 65 and at age 50 were only 50 percent of full entitlement. The 1983 Social Security Amendments set a floor of 71.5 percent of a full benefit, but did not eliminate reductions. Today, the average benefit paid to a disabled widow(er) is only $322 a month, $18 below the SSI level.

These restrictions not only cause significant hardships, as illustrated by letters from our members, they are perceived as an unfair denial of Social Security protection paid for with their hard earned wages.

Except for the addition of a trial work period, no changes have been made to bring disability criteria for surviving spouses into line with that applicable to workers or, since 1974, to disabled applicants for Supplementary Security Income (SSI).

State Disability Determination agencies must issue two or three separate, contradictory decisions. The increased participation of women in the paid workforce has multiplied the frequency at which surviving spouses are determined to be "disabled" and qualified for benefits on the basis of their own wage records yet "not disabled" on the basis of a deceased spouse's wage record which would mean a higher monthly benefit. Since the SSI program began, three sometimes contradictory decisions are often required. Disabled surviving spouses are "disabled" as workers, "disabled" as SSI applicants, and "not disabled" as widows or widowers.

Mrs. Lillian Moore of Dunkirk, New York, was left with a ten year old child when her husband died 11 years ago. Because she was eligible for mother's benefits, she still meets the seven year criteria for widow's disability benefits, but she is one of thousands of widows who do not meet the more stringent definition of disability. So her only income is Supplemental Security Income, awarded to her as a disabled individual after she became impoverished. She wrote to former Congressman Roosevelt:

> "Please tell me what I can do. I have been informed that I can apply for my widow's pension on my husband's pay record if I am 60 years old. I wish I could apply sooner. Is this possible? And if so what percentage would I receive? I want to wait till I am 65, but I may lose my home if I do not get more income soon.

Mrs. Hattie Radford of Indianapolis, Indiana, disabled since 1983, receives $288 a month based on her own wage record. She has been denied benefits as a disabled widow. She writes:

> "I applied for Andrew's benefits in July 1985. They keep turning me down. Andrew was getting more than I am getting so if I can get his, it will help me out a lot. Please, Mr. Roosevelt, if you can will you help me get these benefits?"

We question why benefits are actuarially reduced for any individual whose impairments are so severe that gainful activity is totally precluded. Second, we question why a more stringent definition of disability is still in use 20 years after the disabled survivor benefit was first approved and 13 years after State agencies began making SSI disability determinations relying on the same disability definition used to evaluate disabled wage earners.

One troubling aspect of the seven-year phaseout of entitlement to survivor's benefits to disabled widow(er)s is that a benefit based on a survivor's own short-term employment is inadequate. A second problem is that a widow who has no other Social Security credits could now enter the workforce the day she was widowed, work past the seven-year deadline for survivor's benefits and still not qualify for worker's benefits.

To be eligible for Disability Insurance benefits, a worker must be "fully insured" in addition to having Social Security covered employment in five out of the ten years prior to onset of disability. With the maturity of the Social Security system, seven years of work no longer fully insures a worker 55 or more years of age.

Mrs. Polly Keene Maynard of Silver Springs, Florida, -- after 26 years of marriage and five children -- was left a widow in 1972. Ten years later her sciatic arthritis reached a stage where she was no longer able to work, even part-time.

> "I applied for disabled widow's benefits and was denied because they said it was not within the time limit of seven years. . . They said I didn't have enough credits on my own record. . .They told me about SSI, but they said if I owned anything that was worth $1500, I would have to sell it. My furniture is not much, but I couldn't replace it for $1500. . . . My dear deceased husband thought we would be secure in our old days. He always paid in the maximum in Social Security because he said it was for our benefit. Well, I need mine now and I think it's due me."

We urge the Council to reiterate the recommendation of the 1979 Advisory Council that disabled widows of any age be provided unreduced survivor's benefits. We also ask that you recommend the repeal of the more restrictive definition of disability and the phaseout of survivor's entitlement after seven years.

DISABLED SPOUSES AND ATTENDANT SPOUSES

The denial of early retirement benefits to disabled spouses is inconsistent with the philosophy of the Disabilility Insurance program that disability entitles an individual to be treated as if he or she had reached full retirement age. Current law provides a spouse benefit for a retirement-age spouse, but presumes that a spouse who has not yet reached retirement age is capable of gainful activity. A disabled spouse is no more able to enter the paid labor force than is a disabled widow or widower. The 1975 Advisory Council called attention to this problem and recommended that eligibility for unreduced spouse's benefits be extended to disabled spouses of disabled or retired workers.

Clifford F. Scheller of Brooklyn, New York wrote Mr. Roosevelt:

> "I am not working anymore because of Narcolepsy. I can never work again. So with my age, they gave me a very hard time, but with the help of a judge he got my disability Social Security, thank God.
>
> "My wife, who has epilepsy, was on SSI and Medicaid and they took her off when I went on Social Security Disability. It's very hard for both of us to live on one check and they tell us she cannot receive anything until she is 62 years old. Can you help us in some way and let us know what we should do?"

We urge this Council to respond to our member's question and reemphasize that adequacy and equity both demand unreduced benefits for disabled spouses of Social Security beneficiaries.

Eight years ago, the 1979 Advisory Council addressed the issue of providing a spouse benefit for a Social Security beneficiary who was so disabled as to be in need of full time care. Unfortunately, it rejected the proposal as too restrictive to help many who were equally in need of a personal attendant. The National Committee finds this a specious argument. The Social Security Act provides benefits to a retirement-age spouse of a retired or disabled worker or to a younger spouse caring for minor or adult disabled children. Spouses without such responsibilities are not eligible for benefits until they reach retirement age. However, if a wife who is not old enough for retired spouse benefits cannot enter the paid labor force to supplement the family's income because she is caring full time for her disabled husband, it is neither equitable nor consistent with the purposes of the Social Security law to withhold spouse benefits.

We recommend that when a Social Security beneficiary is so disabled as to need full time care, a spouse benefit be provided in the same manner as benefits are now provided to a parent caring for an adult disabled child.

TRIAL WORK MONTHS/SUBSTANTIAL GAINFUL ACTIVITY

The Disability Insurance program offers disabled workers nine trial work months followed by three additional months without loss of benefits as an incentive to disabled workers to test their ability to return to the work force. If the trial work program is to be an effective incentive, as the law intended, the current standards for measuring "trial work" must be modified and kept up to date.

We would like to compare the current minimum wage, which is itself out of date, and the $75 in monthly earnings which define a "trial work month." $75 equates to an ability to work 22 hours a month - one hour each weekday - at the minimum wage of $3.35 an hour.

We urge the Advisory Council to recommend that a "trial work month" be redefined to substantially increase the dollar value by which a trial work month is measured.

We also urge a partial restoration of trial work months when a disabled worker attempts to work and subsequently suffers a lengthy period of full disability.

A corollary problem is the definition of "substantial gainful activity" combined with the all or nothing nature of Social Security disability entitlement. An ability to earn $300 a month, or the equivalent of forty hours each month at the current minimum wage, is considered "substantial gainful activity," thereby triggering a discontinuance of monthly disability insurance benefits.

A National Committee member, reporting on her mother's death after a five-year fight against cancer, wrote:

> "At the beginning of her illness, she was willing to work, but her 'totally disabled' status prevented her from finding a low-paying, part-time job. The result was that her morale suffered and she felt 'useless' to use her own words. Considering the medical costs she was incurring, it was not wise for her to take even a small job and cut her benefits in the process."

We urge that "substantial gainful activity" be redefined. $300 isn't even the Supplementary Security Income assistance level!

CONTINUING DISABILITY REVIEWS AND LONG-TERM DISABLED

Congress requires the Social Security Administration to conduct periodic Continuing Disability Reviews to determine if a once disabled worker is still entitled to monthly Disability Insurance benefits. We do not object to these reviews. But there is a point in time when we must realistically concede that, even if partial recovery occurs, jobs do not truly exist in the economy for an older disabled individual who has been out of the labor force for an extended period of time. Moreover, if a disabled individual is able to do work he or she has done at any time in the prior fifteen years, disability benefits are denied or terminated even if that past relevant work no longer exists in the national economy. Should the threat of cessation of benefits hang forever -- like a Sword of Damocles -- over the heads of long-term disabled individuals approaching retirement age?

We urge that benefits be allowed when previous work no longer exists and there are no other jobs in the economy which the disabled individual is capable of performing.

Second, work experience more than ten years in the past should not be considered "relevant" when a severely impaired worker can no longer perform his or her most recent work.

Third, we recommend that a disability beneficiary cease to be at risk benefit termination from a continuing disability review if he or she is age 55 and has been on the disability insurance rolls for 15 years. For each additional year of age, the threshold number of years on the rolls could be reduced by one year.

RECENCY OF WORK TEST

Women workers are the most likely to lose eligibility for disability benefits by failing to meet the recency of work test. As our primary caregivers for both minor children and adult family members in need of aid and attendance, women are at risk of losing their disability insured status whenever they leave the workforce to care for family members.

We urge the Council to recognize the importance of this caregiving and recommend the recency of work test be modified to exclude time out of the paid labor force for child care or adult care responsibilities.

PUBLIC EMPLOYEES

In addition to the benefit reductions imposed by the 1977 and 1980 Amendments, a "disability cap" was imposed by the 1981 Budget Reconciliation Act and a "windfall elimination provision" was included in the 1983 Social Security Amendments to prevent public employees from being "overpensioned." The cumulative effect of these changes warrants a thorough review to insure that workers who have careers divided between the public and private sector are not inequitably "underpensioned."

Public wages are not counted in determining the basis of the 80 percent "cap," but public wage-related benefits such as worker's compensation or disability retirement are used to reduce the amount of Social Security which can be paid.

A further reduction is now imposed on public annuitants with less thas thirty years of Social Security employment. This "anti-windfall" change, results in public annuitants receiving Social Security disability benefits smaller than those paid to other workers with identical Social Security wage records.

We strongly urge the Council recommend a study of the combined effect of these recent changes on the equity and adequacy of Social Security payments to disabled workers with mixed public and private work careers.

BENEFIT ADEQUACY

Congress, in 1980, amended the Disability Insurance Program to reduce future disability awards. All disabled workers under age 47 were required to count up to five additional years of earnings in determining monthly benefits. Disabled women workers who had spent years as unpaid homemakers or caregivers were most severely affected.

On average, women awarded disability insurance benefits in 1986 receive only $363.20 per month, almost 18 percent less than women who qualified for benefits eight years earlier. Men who came on the Disability Insurance rolls in 1986 receive $535.10 a month, 13 percent less than benefits currently being paid to disabled men awarded benefits in 1978.

As a result of benefit reductions and the increased number of years which must be counted in averaging income, a staggering 30 percent of unmarried, disabled women awarded benefits after the 1980 Amendments are receiving means-tested cash assistance and 40 percent are receiving non-cash public assistance such as housing subsidies, energy assistance or food stamps to supplement inadequate Social Security Disability Insurance benefits. For unmarried disabled men the comparable figures are 16 percent receiving means-tested cash assistance and 20 percent in-kind benefits.

We believe it is appropriate to ask whether Disability Insurance benefits have been reduced to the point they no longer fulfill the primary purpose of the Disability Insurance Program.

We urge the Council recommend a thorough review of the adequacy of Social Security Disability Insurance benefits in light of recent economic performance and changes in law enacted in the past ten years.

Chairman **Jacobs**. We are aware of the fact that what you really meant to say was to reappear before us. Ms. McSteen, you are most welcome. Both of you have made contributions to the record for which we are grateful. We thank you.

This concludes the hearing on the disability question.

[Whereupon, at 12:01 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF EILEEN BRADLEY, ASSOCIATE COMMISSIONER FOR HEARINGS AND APPEALS, SOCIAL SECURITY ADMINISTRATION

Mr. Chairman and Members of the Subcommittee:

I am pleased to offer this statement for the record discussing the subcommittee's question regarding the Social Security Administration's (SSA) intentions in developing regulations governing the representation of claimants.

My May 13, 1987, statement before the subcommittee outlined the relevant law and regulations, Mr. Chairman, and rather than repeat that background information, I have appended that statement to these remarks. However, as I indicated then, the current fee authorization and payment process has serious flaws. It is extremely cumbersome and labor-intensive, diverting resources from the agency's primary mission to hear and decide cases. It is inefficient, sometimes causing attorneys to wait long periods for payment of approved fees. The rules governing fee authorization are vague and imprecise, and can lead to inequitable results. In short, there is widespread agreement that the current process needs reform.

I also testified in May that we were committed to developing proposed regulations to resolve these issues, and we have made substantial progress toward that goal. We have reviewed all the current regulations governing representation of claimants. Those regulations not only cover fee authorization and payment, they also define the circumstances under which fee authorization is required and prescribe procedures for suspending or disqualifying representatives. We convened a panel of administrative law judges to assist in reviewing these regulations, and we now have a set of draft regulations which we believe address all of the issues regarding representation.

However, these draft regulations have not yet been submitted to Commissioner Hardy. We do not plan to publish any proposed regulations before the Congress has concluded its current consideration of the attorney fee proposal included in the budget reconciliation legislation.

In summary, Mr. Chairman, we believe that the work we have done to date will prove to be both necessary and useful no matter what form any legislation may take.

Attachment

STATEMENT

BY

EILEEN BRADLEY

ASSOCIATE COMMISSIONER

OFFICE OF HEARINGS AND APPEALS

SOCIAL SECURITY ADMINISTRATION

HEARING ON ATTORNEY FEES IN SOCIAL SECURITY DISABILITY CASES

SUBCOMMITTEE ON SOCIAL SECURITY

HOUSE COMMITTEE ON WAYS AND MEANS

MAY 13, 1987

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Good morning. I am pleased to be here today to discuss the Social Security Administration's fee authorization and payment processes in Social Security disability cases.

My prepared remarks focus on what steps the Social Security Administration has taken to date regarding fee authorization in response to the Inspector General's Report, why we believe that action was necessary, and what our plan is for the future. Before turning to these matters, I think it would be helpful to discuss the statutory and regulatory bases for the fee authorization and payment process which applies to all Social Security cases, the vast majority of which involves disability benefits.

Fee Authorization and Payment Process

Section 206(a) of the Social Security Act authorizes the Secretary of Health and Human Services to prescribe by regulation the maximum fee that a representative may charge or collect from a claimant for services performed before the Secretary. Although the Act imposes no specific limits on an allowable fee, it mandates that when the Secretary makes a favorable determination, and the claimant is represented by an attorney, any authorized fee must be reasonable. Nor do the current Federal regulations implementing this authority specify a maximum fee; rather, they prescribe the criteria to be applied in determining a reasonable fee. These criteria include the extent and type of services that the representative performed, the complexity of the case, the amount of time spent on the case, the results achieved, and the level of review to which the claim was taken.

Any representative seeking to charge a fee for services before the Secretary must file a written petition with SSA. The adjudicator who ruled on the claim, usually an Administrative Law Judge (ALJ), then determines the fee on a case-by-case basis, bearing in mind the purpose of the Social Security program to provide a measure of economic security for program beneficiaries and applying the regulatory criteria. If either the representative or the claimant objects timely to that determination, it is reviewed by the next higher level in the organization. After this administrative review, however, there is no right to judicial review.

In addition, if a Social Security claimant was represented by an attorney and was granted benefits, the Act requires that the Secretary certify payment of the authorized fee directly to the attorney from the past-due benefits of the claimant. In administrative proceedings, that payment is the smallest of: (1) 25 percent of the total past-due benefits; (2) the amount of the attorney's fee as determined by the Secretary; or (3) the amount agreed upon by the claimant and the attorney. Notwithstanding the expectations of some attorneys, this provision establishes neither a presumption nor a standard that attorney fees will be 25 percent of past-due benefits. Rather, the withholding provision establishes an escrow account to ensure a source for payment of reasonable attorney fees. Regrettably, considerable confusion appears to exist about the intent of this provision. Some attorneys have interpreted it to establish the expectation that approved fees should equal 25 percent of past-due benefits. Our reading produces a contrary interpretation.

As we understand the Congressional intent underlying these provisions, the statute confirms the claimant's right to choose a qualified representative if representation is desired. It directs SSA to set maximum fees for services rendered, thus tying fees charged to specific services that a representative provided to a particular claimant. When that representative is an attorney and past-due benefits are payable to the claimant, the statute also ensures that there is a source of compensation for the services performed. Finally, the statute places SSA in the role of overseer, protecting the economic security interests of claimants through the requirement that fees be reasonable.

These fee provisions represent a significant workload for SSA, especially at the ALJ hearing level, where representation of claimants usually first occurs. Currently, claimants are represented in 80 percent of ALJ hearings, and in 64 percent, the representative is an attorney. At the hearing level in Fiscal Year 1970, 3,800 fee petitions were processed and $2 million in fees were authorized. In Fiscal Year 1985, 86,000 petitions were processed and $114 million in fees were authorized.

Problems with Fee Authorization and Payment

According to the Inspector General's Report, SSA's management of the fee authorization process has resulted in excessive fee approval practices. I will not repeat that discussion, Mr. Chairman. However, I wish to emphasize that SSA believes that so long as the Congress continues to maintain SSA's statutory responsibility to review, determine, and disburse fees, one instance of excessive fees that adversely affects claimants' economic security interests is one too many and cannot be tolerated. We have a statutory responsibility that we will meet.

Interim Steps Taken to Date

The Inspector General's finding that SSA was failing to protect the economic security interests of a significant number of claimants compelled immediate and decisive action on our part to strengthen our management of the current attorney fee process until we develop and implement the long-term reform of the entire fee authorization and payment process that we believe is warranted.

Therefore, on March 31, 1987, I amended the administrative delegations of authority to the ALJs so that ALJs may authorize fees up to the new limit of $1,500 in any case rather than the previous limit of $3,000. If the total fee to be approved exceeds $1,500, the fee petition and supporting documentation, including the ALJ's recommendation, must be forwarded to the Regional Chief Administrative Law Judge for action. We selected $1,500 because the average fee for the last 3 years has been between $1,100 and $1,500, and because this threshold provides us a way to making sure that fees in excess of $1,500 are clearly justified.

I have not imposed any hourly rate limit. I have not established any maximum fee per case. We have also installed a management oversight system that will ensure that this revised delegation of authority does not adversely affect processing times. I am attaching to this statement a copy of my March 31 memorandum specifying revised agency policy for the determination of fees.

SSA's Plan to Improve the Fee Determination and Payment Process

We are reviewing the entire fee authorization and payment process from top to bottom. We are firmly convinced that this process needs fundamental reform. Our goal is to publish proposed regulations by the end of this summer. I have the Commissioner's full support in moving forward as expeditiously as possible.

Any SSA system for determining and paying representatives' fees should be designed to achieve two primary objectives: (1) the fee process should produce fair, equitable, and consistent fees which protect the economic security interests of claimants and which fairly compensate representatives for their services, and (2) the process should ensure timely reimbursement for services. We seriously question whether the current system achieves either objective. Based on the Inspector General's report and on our own experience, we know that some excessive fees have been authorized, and we also know that the fee approval process has at times been cumbersome.

The solution which the Inspector General has proposed does not, in our opinion, adequately address our concerns about the fee approval process. The Inspector General proposes to amend the fee regulations to provide that "fees are acceptable up to 25 percent of past due benefits as long as they do not exceed the equivalent of $75 per hour based on a reasonable number of hours claimed by attorneys for services." This recommendation is based on the fact that $75 per hour is the standard established under the provisions of the Equal Access to Justice Act. No data support the conclusion that $75 per hour is an appropriate rate for Social Security work generally or for all areas of the country. Furthermore, the Inspector General's proposal does not address the issue of the legitimacy of the hours claimed by attorneys for their services, nor does it deal with our administrative concern that reimbursement be timely paid.

Improving the attorney fee process will require us to focus on two aspects of fees: the hourly rate which attorneys should be compensated for their services; and the time that attorneys devote to client services in each case. This focus is essentially the "lodestar" approach for fee determination which courts have adopted under a variety of statutes. Under this approach, fees are based on the number of hours reasonably expended by an attorney in a case multiplied by a reasonable hourly rate. We believe that this approach should be considered for use at the administrative level as well.

We have begun to develop regulatory specifications to establish an attorney fee process that will apply this lodestar approach to the administrative approval of attorney fees. Our current strategy for regulatory revisions and improvements in the fee authorization and payment process includes several elements. We will propose the establishment of reasonable hourly rates for attorney compensation which reflect geographic and regional differences in prevailing attorney fees and which can be adjusted based on changes in prices or wages. We seek to develop regulatory guidelines to assure that the hours claimed by attorneys as services on behalf of their clients are reasonable and appropriate.

We intend to retain Administrative Law Judge involvement in the fee determination process by having our judges review and certify services pursuant to these guidelines. We will utilize modern technology to expedite, and to the extent possible, automate the payment of fees. We expect these improvements will better protect claimants and benefit their representatives by providing greater certainty and more timely payment of approved fees.

In sum, Mr. Chairman, we believe that the interim action set forth in my March 31 memorandum is both a reasonable and necessary intervention to protect claimants until we can implement these long-term reforms. As I mentioned earlier, I am confident that we can publish proposed regulations by the end of the summer. That may be an ambitious goal, but I believe that we can achieve it.

I would close with a quote from a letter I received recently from an attorney summing this matter up nicely:

> A proper balance must be struck between protecting the public and paying reasonable attorney's fees to those representing the public.

I would be happy to answer any questions you may have.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Social Security Administration

Refer to:

Office of Hearings and Appeals
PO Box 3200
Arlington VA 22203

MAR 31 1987

MEMORANDUM TO: All Regional Chief Administrative Law Judges
All Hearing Office Chief Administrative Law Judges
All Administrative Law Judges
OHA Headquarters Executive Staff

FROM : Associate Commissioner

SUBJECT : Revised Delegations of Authority for Administrative Law Judges to Determine Fees of Representatives - ACTION

I. INTRODUCTION

Section 206(a) of the Social Security Act authorizes the Secretary of Health and Human Services to prescribe the maximum fee that a representative may charge or collect from a claimant for services performed before the Secretary. Although the Act imposes no specific limits on an allowable maximum fee, it mandates that any authorized fee must be reasonable. To protect the right and option of Title II claimants to choose attorneys as their representatives, the Act authorizes SSA to withhold up to 25 per cent of a Title II claimant's past due benefits to ensure an available source of compensation for services performed.

The Federal implementing regulations do not specify maximum fees; rather, they prescribe criteria for evaluating fee petitions and determining reasonable fees for representatives in both Title II and Title XVI proceedings. The fee so determined is the maximum fee that may be collected in that case. A primary consideration in evaluating fee petitions is the purpose of the Social Security program; namely to provide a measure of economic security for program beneficiaries. Finally, in keeping with the Act, the regulations provide for the direct payment of authorized fees to attorney representatives from the withheld past due benefits payable to the claimant in Title II actions.

In summary, both the statute and its implementing regulations reflect three principal objectives: (1) to ensure that claimants who choose to be represented have access to qualified representatives, including attorneys; (2) to ensure that any such representation is procured at a fair price in light of the need to protect claimants' economic security interests; and (3) to ensure, in the case of attorney representatives in Title II proceedings, a source of compensation for services performed.

The Office of the Inspector General has issued a recent report concluding that OHA's fee authorization process has at times permitted the charging of excessive fees to claimants and thus failed to adequately protect claimants' financial security interests as required by the statute and implementing regulations.

II. THE INSPECTOR GENERAL'S REPORT

On January 14, 1987, the Office of the Inspector General (OIG) issued a report entitled, Improvements Needed in Attorney Fee Process Could Save SSA Beneficiaries Millions. The Report concludes, among other things, that "Office of Hearings and Appeals (OHA) Administrative Law Judges (ALJ's) were generally not evaluating attorney fee petitions in accordance with regulations implementing the requirements of the Social Security Act.... As a result, a significant number of claimants have paid what appear...to be excessive fees," and thus, the agency may be failing to protect the economic security of claimants.

The Report found that the regulatory criteria for evaluating fee petitions cover the appropriate factors--extent and type of services, complexity of the case, level of skill and competence, amount of time expended, results achieved, and level of review to which the claim was taken. However, the Report also found that "instead of objectively evaluating fee petitions [under] the regulations, ALJ's were for the most part giving perfunctory approval to fee arrangements agreed to between attorneys and clients."

Although the fee authorization requirements for services before SSA and the provision allowing 25 per cent of past due benefits to be withheld for payment of attorney fees are unrelated, that is, the amount withheld is not a factor in a fee authorization, the two have in practice become intertwined. Commonly, an attorney and claimant sign a contingency agreement providing that the attorney will receive 25 per cent of past due benefits if successful; nothing, if unsuccessful. Whether or not the 25 per cent amount results in a reasonable fee appears to be a matter of happenstance. The Inspector General's Report noted that such contingency fee agreements and what the Inspector General's Office observed to be an "institutionalized reluctance by ALJs to question the judgment of fellow attorneys on the fees requested" contributed to "noncompliance with regulatory and procedural requirements" relating to attorney fee authorization.

Employing the standard established in the Equal Access to Justice Act of $75 per hour as a measure, the Inspector General's analysis of a sample of 2,000 fee petitions showed that 45 per cent exceeded $75 per hour, with 20 per cent in the $75-99 per hour range, 21 per cent in the $100-199 per hour range, 3 per cent in the $200-299 per hour range, and 1 per cent exceeded $300 per hour. The Inspector General reported one instance in which an approved fee request resulted in an hourly rate of $750. OHA Headquarters review of some fee requests has also identified fee approvals in this latter range. The Inspector General recommended that the current regulations be revised to provide that "fees are acceptable up to 25 per cent of past due benefits as long as they do not exceed the equivalent of $75 per hour based on a reasonable number of hours claimed by attorneys for services." However, the Inspector General also indicated that other alternatives might be acceptable so long as the ultimate result of "fair fees" is achieved.

III. ACTION REQUIRED

That the fee authorization and fee payment processes have been troublesome and lingering issues in SSA is generally acknowledged. In the past, the Administration submitted legislative proposals to amend the Social Security Act to delete the fee authorization and withholding provisions in the belief that private contractual arrangements between claimants and their representatives need not be regulated. Congress did not enact those proposals and has indicated very recently its continuing belief that claimants still need protection from excessive fees and the assurance of adequate access to effective representation provided by the withholding mechanism.

In addition, it has been noted in OHA, and especially by several members of the OHA Attorney Fee Panel, that the continuing growth of the fee authorization workload and the attention it should be given are detracting from the primary mission of the Administrative Law Judges; namely, to hear and decide cases.

I recognize that no easy resolution of the attorney fee issue, even on a short-term basis, may exist. But I am convinced that all of us in OHA are disturbed by the findings of the Inspector General's report, by any abusive fee practices and ~~by~~ any failure on our part to protect the economic security of beneficiaries.

Having carefully considered the Report and other evidence that has accumulated over time in OHA, and having reviewed the issues raised in the Report and elsewhere with the Inspector General's office and other SSA executives, I am compelled to conclude that immediate action is warranted to improve our management of the representative fee process. Indeed, the Report indicates that management action can be effective in improving the consistency and fairness of fee authorizations. Thus, I have determined that revising the current fee authorization process as set forth below is the preferred short-term course of action.

Second, I have also concluded that we must devise and implement, as expeditiously as possible, an action plan that will in the long-term, streamline the fee authorization and payment process and achieve the following objectives:

- The fee authorization process should produce fair, equitable, and consistent fees, which both protect the economic security interests of claimants and fairly compensate representatives for their services; and

- The fee authorization and payment processes should be simplified to ensure more timely reimbursement for quality services provided by representatives.

Establishment of a new system that meets these objectives will take some time and a coordinated effort among the various offices in SSA involved in setting policy, and authorizing and paying fees to attorney representatives. Nonetheless, I am committed to making this effort a priority OHA objective.

In the meantime, as an interim measure until a new system is put into place, I am amending the current determination authority regarding fees for representation of claimants (OHA Handbook 1-220/226 and Interim Circular No. 122) as follows, effective immediately:

- ALJs may authorize fees up to $1500 in any one case. If the total fee to be approved exceeds $1500, the fee petition and supporting documentation (including the ALJ's recommendation) must be forwarded to the Regional Chief Administrative Law Judge for fee authorization. In all other respects, the provisions in the Handbook and IC 122 remain in effect.

Effective execution of OHA's responsibility for administrative oversight has been clearly hampered by the lack of data concerning representative's fees. I am, therefore, instituting an interim report requirement for Hearing Office ALJs and for Regional Chief Administrative Law Judges that is consistent with reported information maintained in Headquarters as follows:

- Hearing Office ALJs: On the first working day of each month, the Hearing Office shall forward to the Regional Office copies of all fee petitions that have been authorized in the previous month.

- Regional Chief ALJs: The Regional Offices shall submit to the Office of the Chief Administrative Law Judge by the 15th of each month a Fee Authorization Report, which, using the format provided at Attachment A, reports on information on fees authorized at the Hearing Office and Regional Office levels in the prior month.

I recognize that modifying the delegations of authority imposes an increased workload on the Regional Offices. Nonetheless, to achieve consistent, uniform and equitable fee determinations, I expect that the Regional Chief Administrative Law Judges will ensure that mechanisms are in place to manage this workload effectively and that each and every fee authorization will be given appropriate consideration under the governing regulations. I have directed the Office of the Chief Administrative Law Judge to work with the Regional Chief Administrative Law Judges in instituting the Fee Authorization Report to ensure that this workload is processed efficiently and expeditiously.

This interim procedural change is not intended to protract the payment process. All fee authorizers are reminded that past due benefit information need not be available before proceeding to review a fee petition. Indeed, representatives should be reminded that fee petitions can be submitted and reviewed *before* past due benefit information is available. If a representative has a contingency agreement for a percentage of past due benefits, he or she will generally wait until this information is available, but the 25 per cent of past due benefits restriction concerns only direct certification of payments to attorney representatives, *not* fee authorization. If the representative/claimant agreement is not based on a contingency fee arrangement, fee petition review and authorization should proceed without any delay.

IV. CONCLUSION

The Inspector General's report will in the long run, I believe, prove to be extremely beneficial to all of the parties to the fee process--SSA, claimants and representatives. Authorization and payment of fees has been a nagging problem for some years; a new system that streamlines the process and employs the capability that modern technology affords would go far toward achieving our objectives of timely reimbursement for services at a fair and reasonable price.

Eileen Bradley

Attachment

cc: Louis D. Enoff, Deputy Commissioner for Programs
    Enid Borden, Deputy Commissioner for Policy
        and External Affairs
    Donald A. Gonya, Chief Counsel for Social Security
    Sandy Crank, Associate Commissioner, Office of
        Retirement and Survivors Insurance
    Richard P. Kusserow, Inspector General

Fee Authorization Report

Report Format/Periodicity

Each Regional Office shall forward its monthly report in the following format:

Total # Requests		Total $ Amount		Total $ per Hour		Average Proc. Time in Days	
Received	Authorized	Requested	Authorized	Requested	Authorized	Dec./Auth.	Receipt/Auth.

Summarize monthly requests/authorizations for each Hearing Office. Note that two processing time measures are required; the first should be total elapsed time from the date of the ALJ decision to the date of authorization, and the second is total elapsed time from the from the day the fee petition is received in the Hearing Office to the time it is authorized in the Hearing Office (for authorizations at or below $1500) or in the Regional Office (for authorizations above $1500).

Summarize monthly initial requests/authorizations for the Regional Office.

Summarize monthly review requests/authorizations for the Regional Office.

A report summarizing the previous month's activity should be transmitted by Mailway to the Office of the Chief Administrative Law Judge by the 15th day of the following month.

American Psychiatric Association

1400 K Street, N.W., Washington, D.C. 20005 • Telephone: (202) 682-6000

STATEMENT OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

ON

SOCIAL SECURITY DISABILITY ISSUES

TO

THE HOUSE WAYS AND MEANS SUBCOMMITTEE ON
SOCIAL SECURITY

OCTOBER 6, 1987

The American Psychiatric Association, a medical specialty society representing more than 34,000 psychiatrists nationwide, is pleased to present testimony focusing on Disability Reviews. In addition to detailing general comments and concerns that APA has about the disability review process; we will summarize the history of APA's participation in the 1980s with the Social Security Administration (SSA) and the Congress on behalf of the mentally ill; the development of revised Listings of Mental Impairments; psychiatry's programmatic involvement in the disability process; the issue of multiple impairments in disability determinations; the APA-SSA disability research process; and our recommendations for areas of the disability process which still need further modification. APA will also comment on concerns about the need to assist those individuals who "fall between the cracks" of the disability system and the rehabilitation system.

History of APA Involvement with the Disability Process

In 1982, APA expressed concerns to then HHS Secretary Schweiker, the Senate Committee on Finance, the Senate Special Committee on Aging, the House Ways and Means Committee, and the Commissioner of Social Security about SSA actions through its Continued Disability Investigation process regarding the continued entitlement of Social Security beneficiaries to disability benefits. Because of longstanding concern about those individuals with mental impairments and the issue of disability and the inability to work because of mental impairment, APA believed that the SSA efforts were creating severe hardships for the mentally ill disability beneficiaries and their families through unwarranted benefit terminations.

Congressional concern about the plight of thousands of disabled Social Security beneficiaries—underscored by the groundswell of public outrage—led to the Social Security Disability Benefits Reform Act of 1984. The amendments to the Act mandated many changes for which APA had fought. The following areas were of major concern to APA:

1. a new medical improvement standard;
2. consideration of the combined effect of multiple nonsevere impairments in the disability determination process;
3. the establishment of a commission to conduct a study of the evaluation of pain in determining disability;
4. the conduct of face-to-face reviews on a trial basis in several states;
5. the use of psychiatrists (The Amendments also refer to psychologists) in cases involving a mental impairment, particularly where denial is contemplated; and
6. most importantly, the imposition of a moratorium on review of mental impairment cases, pending the development of revised medical criteria for evaluating mental impairment.

Since the passage of the Amendments, APA has continually responded to a host of regulatory and administrative actions promulgated by SSA affecting the mentally impaired. These included the development of the Listing of Mental Impairments and the failure of SSA to retain language on psychogenic pain and substance addiction disorders. APA commented on the process of continuing disability reviews and determinations by noting the fluctuating nature of psychiatric disorders and their relationship to "medical improvement", and the problems of using old and new "Listings" in determinations of mental impairments and disability in the "transition " period. APA testified before the Commission to Evaluate Pain on the subject of psychogenic pain (somatoform pain disorders), as a disabling form of mental illness. Further, we expressed our concern with SSA proposed rules covering the continued payment of benefits pending appeal by suggesting language protecting the mentally impaired and requesting SSA to continue to examine its rules, regulations and procedures that may have an adverse impact on this population.

The APA also supported the recent passage of the Employment Opportunities for Disabled Americans Act which makes permanent the Section 1619 demonstration,thereby removing disincentives to work in the supplemental security income program. APA's involvement in SSA's disability program on behalf of the mentally impaired continues to be steadfast.

APA was intimately involved in the process for establishing criteria for the Listing of Mental Impairments by participating in a special interprofessional-work group co-chaired by two APA psychiatrists and convened by the SSA to develop over the course of eighteen months a new and improved Listings of Mental Impairments. The "old" Listings of Mental Impairments were divided into four groups, reflecting certain disorder categories (Organic Brain Syndrome, Functional Psychotic Disorders, Functional Nonpsychotic disorders, and Mental Retardation). Within each, two sets of criteria --"A" and "B" were designated. The "A" criteria referred to the signs, symptoms and findings necessary to establish the existence of a medically determinable impairment. The "B" criteria set out criteria designed to assess functional limitations which exist as the result of the impairment found to exist under the "A" criteria. In its final report the work group recommended to the SSA that the four categories cited above be expanded to eight categories (Organic Mental Disorders; Schizophrenia and other Psychoses; Affective Disorders; Mental Retardation; Anxiety Related Disorders; Somatoform Disorders; Personality Disorders; and Substance Abuse Disorders). However, and in spite of the work group's recommendation, the substance abuse disorders category was changed to a reference listing prior to the promulgation of the Listings in the Federal Register. The guidelines for use of this reference listing are confusing. New "C" criterion were added to two (chronic schizophrenia and agoraphobics) of the new Listings to clarify functional assessment in those categories. These new Listings of Mental Impairments bear a strong relationship to current psychiatric concepts and nomenclature in DSM III. By so doing, the new listings add clarity and specificity by helping adjudicators to better use medical records and no longer requiring "translation" from DSM III or its revision DSM III-R medical parlance to SSDI parlance. These listings also remain "impairment driven" and not "diagnosis driven" and involvement in the endeavor permits APA to offer assistance to the Social Security Administration in timely review of the listings due to "sunset" on August 28, 1988. Since medical knowledge is continously increasing, the Listings of Mental impairments will need to be updated and SSA will need to develop an appropriate process of review and planning to accomplish this goal.

SSA ought to convene a group of medical experts to review and update current criteria. APA hopes to maintain an ongoing relationship with SSA so that current knowledge will be reflected in SSA guidelines to states.

Psychiatric Involvement in the Disability Process

Psychiatrists are involved in both the disability review process and in the treatment of patients, often acting as expert witnesses on a consultative basis to the SSA office of Hearings and Appeals. Within the disability evaluation process, psychiatrists act as medical consultants for State Disability Determination Services (DDS) evaluating disability claims involving a mental impairment. Psychiatrists at the SSA regional level perform quality review of claims and at SSA central office level participate in third tier review and as advisors relative to policy decisionmaking. Data from August 1986 supplied by the Social Security Administration shows that 377 psychiatrists are working as medical consultants at the DDS providing approximately 7238.7 hours of work per week. Despite the fact that psychiatrists do and will maintain involvement in this review process, it has come to our attention that some state DDS are providing inadequate remuneration to psychiatrists for their services and this should be investigated and rectified.

Multiple Impairments

The appropriate use of medical specialists in claims involving both physical and mental impairments is an area requiring further study. We believe that sometimes such a claim may be unsatisfactorily resolved even though the relevant medical specialists have each rendered their independent assessments. We would suggest that a work group be convened, composed of medical experts from the medical specialties (e.g. cardiology, orthopedics, psychiatry) in order to develop more meaningful categorizations of multiple impairments. The work group's initial goal could be to develop an understanding of the nature of the interaction between physical and mental impairments and their combined impact on an individual's ability to function. Further, they could consider and recommend novel, joint, interspecialty approaches to resolve the problematic case. Information may be gathered through research, investigations, demonstration projects and input from the community. That data can then be used to develop guideliness for the assessment of claims involving these multiple impairments. The APA would be interested in and supportive of such an activity.

APA Research Project

The APA and its psychiatrist members are participating in an important and ongoing research project involving the new Listings of Mental Impairments. Even before the new Listings were in effect, the Social Security Adminstration provided that it be studied, under contract, by the American Psychiatric Association. The "Study of the SSA Methods and Standards for Evaluating Disabilities Based on Mental Impairments" began in June 1985. The purpose of the research is to examine the Listings of Mental Impairments, the Psychiatric Review Technique Form, and the Residual Functional Capacity assessment as reflective of current thinking in psychiatry, in conception and application.

This study is a systematic, scientific assessment which involves 72 of the APA's members who review actual SSA case folders which have been "sanitized" for confidentiality. It is the first time that such a thorough examination of disability and clinical decision-making in psychiatry has been undertaken. All of the psychiatrists received special training on the statutory definition of disability according to the Social Security Act.

Half of the study's psychiatrists received further training on the medical standards and guidelines. The other half did not; they spent additional time understanding the statute in its direct application to claims, without the intervening standards and guidelines. The same 732 case folders were reviewed by psychiatrists trained in the two different ways.

A unique aspect of the case folder review is that the psychiatrists were organized into panels of three members each. Every claim was reviewed by three psychiatrists in each of the study conditions, first independently and then in a panel session. In the panel review the claims were discussed with a goal of reaching a consensus. In one study condition, psychiatrists applied their clinical expertise and their knowledge of the statute to the material in the case folders. In the other condition, the psychiatrists applied the new Listings of Mental Impairments, the Psychiatric Review Technique Form, and the Residual Functional Capacity assessment in addition to their clinical expertise and knowledge of the statute.

Preliminary results will be presented to the SSA shortly. We must point to the fact that this is the first time that SSA has subjected part of its disability process to scientific scrutiny by an outside professional organization. We complement the SSA on undertaking to seek relevant, independent, scientific medical expertise and encourage further studies in this area.

Areas of Further Clarification and Need

Before delineating areas which warrant further action or investigation, the APA would like to go on record as stating that the openness and cooperation of the SSA since the enactment of the amendments has been exemplary. We hope that this continued interaction for the benefit of psychiatrically disabled patients will continue. The following areas need further investigation and action:

a. The status of the Childhood Listings of Mental impairments which have been in preparation for the past two years but have not been promulgated in the Federal Register.

b. Substance addiction disorders (including alcoholism) and pain were not adequately or appropriately dealt with in the regulations and guidelines. The adjudicated guidelines are inadequate and confusing. These areas need further involvement.

c. The 1984 amendments indicated that psychiatrists and psychologists be used whenever possible in all mental cases where denial is involved. This aspect of the amendments needs to be appropriately enforced.

d. A clear policy statement needs to be developed for pain cases with specialty review by psychiatristss, if necessary. APA would be happy to work with SSA to develop guidelinees as to when this review is necessary.

e. Psychiatrists need to be involved in determining the degree of medical improvement. For instance in pain disorder cases with evidence of mental disorder (i.e. somatoform pain disorder anixety and depression) review should be conducted by a psychiatrist.

f. It appears that staffing at the state level for periodic reviews may be inadequate.

g. Those individuals who receive SSDI and return to the workforce lose their Medicare eligibility after 9 months thus causing a hardship. The Congress might consider a demonstration comparable to the Employment Opportunites for Disabled Americans Act.

h. Circulated draft guidelines about changing the Residual Fuctional assessment (RFC) process would have physicians review and sign determinations of patient characteristics they have not evaluated themselves. We are concerned that there is the potential for psychiatrists to be placed in the medically and ethically untenable and unsound position of reviewing documents without appropriate degree of patient review. We would urge SSA to maintain acceptable levels of quality assurance by maintaining training and expertise.

i. In addition, we have concerns about some individuals who "fall through the cracks" of the Social Security and Disability Systems. They are told they are ineligible for disability but assessements under the Rehabilitation Systems Act indicate they are too disabled to become part of that system.

Summary

In sum, APA has had a longstanding history and involvement with SSA and this Committee in working to make certain that beneficiaries with mental impairments receive the appropriate review through the disability process. APA compliments SSA on its foresight in subjecting the Disability Review process to scientific study. Suggestions for areas of further investigation are delineated within the testimony.

PREPARED STATEMENT FOR
HOUSE SOCIAL SECURITY SUBCOMMITTEE
OVERSIGHT HEARING ON DDS ISSUES

by
Susan S. Suter

Mr. Chairman, I am Susan S. Suter, Director of the Department of Rehabilitation Services for the State of Illinois, the parent agency for the Illinois Disability Determination Services. We in Illinois view the federal/state relationship in administering the Social Security Disability Program as a very important one. This unique relationship serves Illinois citizens with disabilities well and we want that partnership to continue.

Commissioner Hardy came to SSA with a mandate to increase productivity and to increase public confidence in the Social Security system. We and the 40 million Americans served by Social Security support her in making Social Security an effective and efficient delivery system which maintains high quality standards.

As you know, this past fiscal year saw significant reductions in resources for the DDSs. It is our experience in the face of these reductions that I wish to speak about today.

In Illinois the changes in DDS funding and program goals meant that we entered Federal Fiscal Year 1987 with a funding cut of 5.7 percent -- this was coupled with a workload increase of 6.4 percent. That is, the money available to Illinois last year represented a cut of $2.1 million from the amount we actually spent the previous fiscal year to run the program. Frankly, at the beginning, we thought this was an impossible task. However, we finished the year within budget and near established productivity goals. How?

First, we had to reduce DDS staff. Our full-time equivalent staff has dropped from a total of 722 in December, 1985 to a low of 591 in August of this year. This was a reduction of 131 FTE positions or an 18 percent decrease in staff. This was achieved through attrition.

These personnel cuts resulted in a higher pending workload for the DDS and a higher caseload for adjudicators. In January of 1986, Illinois' pending caseload per adjudicator was 99. We believe that caseloads above 100 become very difficult for adjudicators to manage. In July of this year, adjudicators' caseloads had risen to 146. The pending caseload for the agency in that same period of time rose from 25,000 to over 32,000 -- a 28 percent increase.

We also severely limited the number of hours which our DDS in-house doctors could work. This caused a bottleneck in the doctors' offices and affected timeliness of cases. Prior to last October, the pending load for our medical staff usually ran around 1,000 cases. During much of the 1987 fiscal year, that pending level ran about 1,600 cases. It peaked at 2,600 cases pending in doctors' offices in November of 1986 and has been gradually coming down since then.

A recent General Accounting Office study said that the disability program nationwide was ordering too many consultative examinations (CEs). We have taken steps to reduce the number of examinations and dollars expended. Our CE rate (the percent of cases for which a CE is purchased compared to the total caseload) has been cut 15 percentage points in the past year and a half. We have also reduced the cost per case (curtailing lab testing, etc.) from $169 in FY 1986 to $122 in FY 1987 for an average savings of $47 per exam. We are still carefully monitoring CEs and operating within the available moneys.

The DDS had to cut back on money spent on medical history or evidence of record. In April of this year, we reduced the fee paid for medical records and reports from treating sources by 20 percent. This will represent an annual savings of nearly half a million dollars but may make the gathering of evidence more difficult. Section 9(b) of the Social Security Disability Benefits Reform Act of 1984 requires development of medical evidence from all treating sources for the past 12 months.

We also cut teledictation services to our consultative physicians to further reduce costs. This was a free service where doctors could phone in and dictate their CE reports directly into a DDS unit which would transcribe the reports and mail them to the physicians for review and signature. This speeded receipt of CE reports and, thus, lowered our processing time.

Along with coping with the problems related to reduced funding, we have had to address declining quality levels. The constraints on resources (reduction of staff, cutback on doctors' hours, high pending caseloads per adjudicator, and limited money for consultative examinations and medical evidence of record) had a predictable impact on quality. In December of 1985, our three-month rolling average for combined Title II/Title XVI accuracy was 100 percent. One year later this figure had fallen to 87.9 percent. Since that time, we have again raised our accuracy rates by forcing adjudicators to adjust their work style in response to limited resources, through enhanced Quality Assurance review, and through increased case review activities by unit supervisors. Our most recent three-month rolling average, ending in July, was an accuracy rate of 98.9 percent.

As I mentioned earlier, we were implementing cost-cutting measures at the same time we were looking for ways to adjust to an increased workload. The major factors contributing to our increased workload were the result of the Social Security Disability Benefits Reform Act of 1984 and court orders affecting the Illinois DDS as well as a resumption of CDR case processing.

It was necessary for us to review past mental case determinations and apply the new mental evaluation criteria mandated by the 1984 legislation, which requires case review by a qualified psychiatrist or psychologist before an unfavorable decision is made on a mental impairment case. The ultimate goal is to obtain psychiatrist/psychologist review on favorable decisions as well.

We completed the comprehensive training on the new Medical Improvement Review Standard detailed in the 1984 Reform Act and resumed CDR case processing last fiscal year. In FY 1987, we processed 100 percent of the cases we were budgeted to do in the time period. We had to stretch resources, doctor time, and adjudicator time to get this done.

We have also completed the major portion of our decision review caseload; these are Young class members whose cessations were replaced using the new medical review standards. This special caseload was also mandated by the 1984 legislation.

Another factor in Illinois' workload has been the Johnson nonsevere court order which requires full vocational development on all denied cases and prevents us from making quick decisions in nonsevere cases. Because the nonsevere caseload makes up about 27 percent of our cases, following this court order has resulted in higher costs and processing times. The recent Supreme Court decision in the Yuckert case will, of course, remedy many of these problems. Freeing our doctors from doing Residual Functional Capacity assessments on these cases will give them more time for other case reviews. This may also help us lower our CE rate.

As a result of resource reductions and workload increases, case processing time has also increased. In July our case processing time was 72.7 days for Title II and 76.0 days for Title XVI. We are above the proposed national goals of 61.5 days for Title II and 67.9 days for Title XVI and significantly above the current standards of 49.5 days for Title II and 57.9 days for Title XVI established in 1981. The 1984 Reform Act made sweeping program changes (e.g., new physical and mental evaluation criteria, a CDR medical improvement standard, evaluation of the combined effects of multiple impairments, etc.). Many legal experts have said that the legislation changed the very definition of disability. Because the program is so much more complex than it was two years ago, it is unrealistic to hold DDSs to processing time goals that applied prior to the 1984 legislation. We feel that the proposed regulations should be finalized and that, in light of the Yuckert decision which will allow us to make nonsevere determinations, we can attain these goals.

The Illinois DDS may have to increase its use of high volume CE vendors to reduce processing time because they provide CE reports quicker than independent physicians. We see this as an unfortunate step. A year and a half ago, we set a goal to significantly reduce our reliance on high volume CE providers. In October 1984, only 15.6 percent of our authorized CEs were performed by independent physicians; by October 1985 that number had risen to 54.5 percent, peaking in October 1986 at 65.7 percent and in June 1987 at 67.7. Currently we are averaging 62 percent.

We worked to achieve our productivity goal. Productivity or PPWY is determined by the number of cases produced per year for every DDS employee. The FY 1987 goal was a cumulative PPWY of 202. In FY 1986 our PPWY was 169.6. Our cumulative PPWY for this 1987 fiscal year was 200.8, an increase in productivity of 18.4 percent. We expect to be able to meet the new FY 1988 goal of 209.9 because of efficiency measures implemented last year and the Yuckert decision.

When we received our funding for this year, we were asked to make major changes very quickly and we experienced some problems in doing so. But we accepted the challenge and we are, we believe, managing the program in a new environment with increasing success while keeping faith with the established program guidelines.

FORTNEY H. (PETE) STARK
9TH DISTRICT, CALIFORNIA

COMMITTEES:
WAYS AND MEANS
DISTRICT OF COLUMBIA
SELECT NARCOTICS

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

Statement of Congressman Fortney H. (Pete) Stark
on Social Security Disability Issues
for hearing on Tuesday, October 6, 1987

Mr. Chairman, I would like to share with you comments given to me by my twelve year veteran case worker on the third issue being considered by the Committee today, namely, "Are SSA's productivity guidelines realistic, and is the method SSA utilizes to measure productivity accurate, consistent, or nationally uniform? If not, how could these productivity standards be improved?"

The SSA productivity measuring system has been designed and refined to be accurate and is probably the most sophisticated system in the federal government. Every completed form is assigned a value. An initial claim is worth so many work units, a redetermination so many work units, an overpayment so many work units, etc. This year every SSA employee is expected to increase productivity levels 6% over last year's goal of 1300 work units.

This system emphasizes quantity over quality. If only pieces of paper are counted, the service which accompanies the form is not considered. The aspect of productivity which looks to producing *abundantly* is prized, while the aspect of producing *effectively* may be overlooked.

Each of us has experienced frustration in filling out even simple forms. Often a claimant needs a thorough and patient explanation to understand the process. In a limited work day, if the incentive is to "count" forms completed, the shorter the interview the better!

If time is spent with uneducated or illiterate people who need more assistance with the forms, the SSA employee/office is going to have a poor rating. Because of this productivity measuring system, my area has the worst rating in the region. Yet, I believe it provides good service to people.

In the past, claims representatives filled out medical forms for claimants. Presently, there is a growing practice to have the disabled person fill out the form. This saves time for the SSA employee, but may result in an inaccurate form.

No work units are given for answering a Congressional inquiry. This leads to "quick guess" answers from claims or service representatives so that he/she can return to work that "counts".

In conclusion, I ask the Committee to consider the following:
1) finding a way to reward effective service as well as the quantity of completed forms
2) considering assigning work units to responses to Congressional staff inquiries.

This will be a challenge since it is impossible to assign value to good service.

FOR THE RECORD

TESTIMONY
FROM VERNON M. ARRELL, COMMISSIONER
TEXAS REHABILITATION COMMISSION
ON THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

PRESENTED TO: U.S. HOUSE OF REPRESENTATIVES
HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON SOCIAL SECURITY
ANDY JACOBS, JR., CHAIRMAN

OCTOBER 6, 1987
WASHINGTON, D. C.

TRC TESTIMONY
U. S. House Social Security Subcommittee

INTRODUCTION

Mr. Chairman and members of the Subcommittee: I am Vernon Max Arrell, Commissioner of the Texas Rehabilitation Commission. The Texas Rehabilitation Commission is a state agency authorized to administer the Social Security Administration's (SSA) disability program in the State of Texas. The disability program has a $39 million annual budget in Texas and is administered by our Disability Determination Division (DDD).

BACKGROUND

The Texas DDD has for many years been a leading state agency in the disability program. We have consistently achieved a high national ranking in the accuracy and timeliness of disability determinations processed. Texas ended FY 1986 with a 97.7 percent accuracy rate (based on a review by the Social Security Administration), well above the minimum rate of 90.6 percent set by SSA. We processed claims faster than the national average, with a yearly average of 65.9 days for each SSDI claim (the national average was 68.8) and 68.7 days for each SSI claim (the national average was 75.8 days).

During FY 1987 we have continued our commitment to excellence in serving disability claimants and beneficiaries. Our accuracy rate, according to federal quality assurance statistics, for the first eight months of FY 1987 was 96%. Initial Title II average mean processing time was about 55 days (8 days faster than the national average), and initial Title XVI average mean processing time was approximately 56 days (11 days faster than the national average).

The national target production per workyear goal was 195. While the actual national average was 189, the Texas production per workyear figure was 216.

Due to the size of our operation, our advanced management information system, and high productivity, we have frequently participated in pilot projects for SSA which were designed to modernize and streamline the national disability determination process.

Some people are asking why Texas, with its outstanding record, is raising issues of concern.

It has been my long-term commitment and that of our Board to keep the Texas Congressional Delegation apprised of the status of the Social Security disability program from the Texas perspective. It is in that spirit that I am before you today.

In February 1984, I testified at joint field hearings in Dallas before the Senate Committee on Aging and the House Subcommittee on Social Security. At that time the Social Security disability program was embroiled in controversy which had seriously weakened public confidence in the program. In the words of a recent report by the Congressional Office of Technology Assessment, "SSA had suffered a severe blow to its esteem with the public." Critics described SSA's policies of that period "as illustrating a commitment to efficiency at the cost of socially desirable service to the public."

My 1984 testimony was in support of additional reforms and standards for determining disability and the uniform application of these reforms on a national basis.

The subsequent Disability Benefits Reform Act of 1984 was the product of a successful collaboration of the House and Senate. After its passage in October 1984, an effort was made to incorporate input from all segments of the public and medical communities toward the development of regulations that would ensure a consistent, compassionate, and humane disability program nationwide. In this decade we have seen the disability program pendulum swing from the height of public respect to the loss of public confidence. With the 1984 reform legislation we saw the pendulum swing in the direction of reform and credibility.

FEDERAL/STATE PARTNERSHIP

In the GAO publication of March 1987 entitled "SSA: Stable Leadership and Better Management Needed to Improve Effectiveness" the GAO states: "...SSA has serious management problems that are not clearly visible to the public, have contributed to crisis situations in the past, and could interfere with SSA's ability to effectively accomplish its mission in the future."

I too have concerns about some of SSA's management policies which seem to indicate a retreat from the atmosphere of partnership with states that has been a hallmark of the disability program for many years.

The Texas Disability Determination Service (DDS) is proud of the partnership we have shared with the Social Security Administration in the past and the role Texas leaders have had in charting its course toward better addressing the needs of our nation's disabled citizens.

In that spirit of partnership I would like to offer some suggestions for improvement in SSA's current management policies that could improve service delivery.

NATIONAL DISABILITY DETERMINATION SERVICES SYSTEM (NDDSS)

The National Disability Determination Services System is a good example of how recent changes have been implemented without obtaining meaningful input from the administering state agencies.

Implemented on July 31, 1987, this new computerized national reporting system was developed to modernize the methods of tracking and reporting disability claim actions and provide other meaningful management information.

At the time of the systems conversion, 7 or 8 states had independent reporting systems associated with their parent vocational rehabilitation agencies. Texas was one of those states. Twenty-two states had WANG systems, and these states had an independent vendor provide the software necessary to incorporate the NDDSS process. The remaining states were on the Social Security Administration Data Aquisition and Response System (SSADARS), and thus SSA provided the NDDSS process.

The evaluation of separate systems such as these with differing capabilities was obviously a situation which needed attention. SSA needed a nationally uniform management information system. The objective was commendable, but the method of implementation was flawed.

Texas and other states with independent systems were given inadequate lead time prior to implementation to develop new computer software to accommodate the new system. The result was chaos in Texas, as we have had to contend with widespread systems problems, backlogs of cases, processing time delays, and overtime on the part of many employees.

This scenerio could have been prevented if advance planning had included input from both large and small states with differing systems.

I challenge SSA to involve states early in the developmental stages of major changes. Together we can address the impact and timetable for such changes. Through early involvement in planning, states will be better able to respond as necessary changes are implemented.

MORE EQUITABLE RESOURCE DISTRIBUTION

SSA should take measures to assure a more equitable distribution of money among the states as case receipt patterns change in response to external factors.

Economic factors in different regions of the country frequently change, creating substantial increases or decreases in the number of disability applications. During the past year surveys of state agencies throughout the country have revealed wide variations in caseload sizes. Some states reported too few cases to maintain productivity goals, while others were severely overloaded. There is no system for equalizing workloads among states to maintain efficiency.

To cite our own experience, the slumping oil economy and the resulting high unemployment rates in Texas and other oil producing states have had a significant impact on applications for disability benefits. The Texas DDS has experienced record case receipts and clearances for many months, many thousand more cases than SSA budget/workload estimates.

Despite these factors, until recently SSA demonstrated limited flexibility in making modifications to DDS budgets commensurate with major shifts in the number of case receipts. In Texas we received a more equitable budgetary/staffing adjustment late in the fiscal year. We hope this represents a trend toward a closer working relationship with SSA.

BUDGET MANAGEMENT

Early budget information is essential for making sound management decisions in any major service delivery program. If state agencies received their budgets from SSA at the beginning of the fiscal year, a much better-managed program would be possible.

Similarly, SSA continues to impose rigid line item controls for staffing levels and DDS expenditures. The lack of budgetary flexibility afforded DDSs by SSA makes it difficult for managers to efficiently utilize authorized funds in a manner appropriate to the individual state's needs. Regional Office approval is required for every expenditure over $500. There is little incentive for state administrators to save money in one area if they can't use it in another.

The Texas DDS has repeatedly asked for a floating full time equivalent (FTE) staffing level. If we had been given this authority during FY 1987 we could have hired additional staff, accelerated the CDR program, implemented face-to-face hearings, and financed these programs with the $1 million surplus we accrued through careful budget management practices.

If the DDSs were given budget flexibility to include a floating FTE level based on SSA's production per workyear goal, the DDS managers would be able to use funds saved in one area and apply the funds to other areas essential to case processing and still operate within an authorized budget. In addition, State agencies should be allowed to buy personal computers and other equipment that could improve productivity and efficiency. Better services to the public can be accomplished through management flexibility geared to the specific state's needs.

SUMMARY

The Social Security Administration has had a long and historically unique partnership with the states through the administration of the disability program. This relationship has been under some strain during the past two years. States have not always been consulted during the planning phases of major projects that would significantly impact service delivery. A recommitment to the spirit of partnership by both SSA and the states would do much to promote program integrity.

By making some adjustments in its budgetary posture, SSA could better reinforce the gains which were so painstakingly crafted by Congress, SSA, state agencies, the medical community, and advocates for the disabled. Among the ideas that deserve serious consideration are:

- A more equitable distribution of resources among states.
- More budget flexibility at the state level.
- Earlier budget estimates provided to the states.
- Floating full time equivalent staffing levels based on production.

Adoption of these changes would go far in building a spirit of trust and partnership and allow us to work together to improve the disability program for the benefit of the disabled citizens we serve.

Thank you for this opportunity to share my concerns with you.

Thomason & French

George H. Thomason
Robert S. French

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October 13, 1987

The Honorable Robert J. Leonard
Chief Counsel
Committee on Ways & Means
United States House of Representatives
1102 Longworth
House Office Building
Washington, DC 20515

RE: Social Security/Attorney Fees

Dear Mr. Leonard:

I respectfully submit an original and six copies of comments for consideration by the Committee on Ways & Means.

1. The Social Security Administration had attempted to gain more centralized control of attorney fees by publishing proposed regulations on August 12, 1986 in the Federal Register. Hundreds of unfavorable comments were received by the Secretary. It became immediately evident that the Social Security Administration could not accomplish centralized control over the attorney fee process through regulatory enactment. The March 31, 1987 internal policy change was the only mechanism that Social Security had available to centralize control over attorney fees and insulate itself from public comment. The March 31, 1987 memorandum issued by the associate commissioner of Social Security has been remarkably effective in creating a bottleneck for the consideration of reasonable petitions for attorney fees. It also allowed the Social Security Administration to engage in wholesale fee cuts as part of a policy to discourage attorneys from handling disability claims.

2. I hope that someone will ask Social Security if the agency receives complaints from clients who have been successfully represented by attorneys in disability claims. Apparently, Social Security officials are the only individuals who have decided that attorneys who helped disabled citizens were being paid too much. Nowhere in any information developed by Social Security is there evidence of dissatifaction among those individuals who have been effectively represented by counsel. The contigency fee arrangement is a highly desirable system which makes competent counsel available to people who must deal with the Social Security Administration. Obviously, Social Security knows that if it can discourage competent counsel from handling these claims it will be possible to deny larger percentages of disability claims being processed. This, I believe, is the primary reason that Social Security has suddenly had great concern over the sums of money being paid to attorneys who win claims.

3. I have already experienced improper procedures being used by Social Security for considering fee petitions within the Regional Chief ALJ office in Atlanta, Georgia. As a result of the March 31, 1987 memorandum, many of my fee petitions now go to the Regional Chief ALJ in Atlanta, Georgia. I am experiencing unusual delay in getting the fee petitions from the Office of Hearings & Appeals to the Regional Chief ALJ. A ninety day delay is not uncommon before the petition is even transferred to the Regional Chief ALJ for his consideration. I also find that employees working within the Regional Chief ALJ's office are responsible for preparing an assessment of my fee petitions. This recommendation then, apparently, is sent to the Regional Chief ALJ who signs the authorization. Totally inappropriate standards are being used for considering fee petitions. Already we have seen an "average fee for service" concept used by the Atlanta Office. This is not within the regulatory criteria but my fees have been set using such criteria.

4. The regulations that are now being proposed are designed to make it virtually impossible for a lawyer to receive adequate compensation. Since that is a desirable result within Social Security circles, it does not surprise me that all attorneys who handle Social Security will be confronted with more cumbersome arrangements to obtain compensation.

5. It is odd that no attorney who has ever handled Social Security claims has been consulted by Social Security in this evaluation process to determine reasonable fees. Apparently, the only people who feel qualified to set reasonable fees are employees of government agencies who are not participating in the private practice of law. Market information concerning reasonable fees have never been given any consideration. The cost of operating an office is ignored when Social Security sets a fee in a specific case. The contingency of compensation is never considered. It is especially odd that no one knows how to set a fee except someone working for Social Security who is not in private practice. It is also odd that Social Security does not desire or elicit any information from practicing attorneys concerning the fee authorization process. Why?

Thank you for considering these comments. Anything that can be done to get rid of the March 31, 1987 policy change would be greatly appreciated by lawyers throughout the United States. I have evidence that lawyers are discontinuing Social Security practices already as a result of the difficulty in obtaining reasonable fees. I will be happy to provide that information if requested. Also, please do anything possible to discourage the Social Security Administration from coming up with more insane ideas about how to design a punitive fee system that is suppose to be "fair" but is only designed to get rid of lawyers who have consistently provided Social Security with a whipping in the Federal Courts in this country.

Very truly yours,

THOMASON & FRENCH

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George H. Thomason

GHT:sc

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REPLY TO WINSTED OFFICE

COMMITTEE ON
RECEIVED
OCT
WAYS AND MEANS

October 8, 1987

Robert J. Leonard, Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Bldg.
Washington, D.C. 20515

Re: Social Security Administration Attorney Fee Legislation

Dear Mr. Leonard:

As an attorney who has been representing Social Security Disability insurance appellants for the past 13 years, I have had extensive exposure to the Social Security Administration and its manner of dealing with attorneys and their fees.

It has become my impression that the Social Security Administration views with extreme disfavor the disability insurance program. The energy devoted by the Administration to various types of procedures which tend to restrict availability of disability benefits is impressive, especially in the light of the lack of energy demonstrated by the Administration in dealing with more routine matters.

After the disability amendments of 1984 put a halt to the random termination of benefits, the Administration seems to have seized upon an attack on representation as a way to reduce its disability case load. The new fee regulations, restricting Administrative Law Judges to awarding no more than $1,500.00 rather than the previous $3,000.00 limit, are certainly an instance of this.

Even if the Regional Chief Administrative Law Judges award the same fees as were previously awarded by the local A.L.J.s, the delay inherent in this process has doubled. An attorney can now expect to wait at least 6 months between the time of a favorable Hearing decision and the time when a check is received for attorney's fees. It is obvious that this has a terribly negative effect on the cash flow of small law practices such as mine.

The Social Security Administration is now proposing even more severe measures on attorneys' fees wherein they will take away individual determinations entirely and substitute their own opinion as to the amount of hours appropriately to be devoted to any particular file, and then award a fee based on a standard hourly rate. The amount of this fee varies region to region, depending upon the relation of personal income to the national average. There is no provision, expressed or implied, for coping with the contingent nature of attorneys' fees in these matters. Social Security is proposing to allow me an hourly fee which is somewhat less than the normal hourly fee charged by attorneys in my region for matters which are paid for regardless of an outcome. Therefore, I would be compelled to take, on a contingent basis for an hourly rate lower than my regular hourly rate, any Social Security Appeal that came into my office. This is obviously not something I would be inclined to do.

The legislation proposed by the Social Security Sub-Committee and approved by the Ways and Means Committee, taking away from the Social Security Administration any involvement in attorney fee setting except in unusual instances is a step in the direction of guarantying the availability of representation.

I certainly support your proposed legislation. The Social Security Administration should be stopped immediately from enacting any further regulations which create greater involvement in the fee process as it is clearly contrary to the best interests of the claimants, contrary to the stated position of the Ways and Means Committee and is an obvious ploy to force skilled and experienced representatives from the field.

Please include this letter in the written statements which you are apparently accepting until October 20, subsequent to a Public Hearing which you held on October 6.

Thank you.

Sincerely yours,

Robert P. Wenten

RPW:dk